MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07623 07615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print) First	ALMETA	Middle GERTRUDE	Last ANDREWS
2a. DATE OF DEATH Month Day Year	May 28 69	2b. HOUR	6:15PM
3. SEX	Female		
4. RACE	White		
5. DATE OF BIRTH	23 Aug. 1897		
6. AGE (In years last birthday)	71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	9 / 5
IF UNDER 24 HRS.: HOURS / MIN			
7a. BIRTHPLACE (State or foreign country)	Calvert Co Maryland		
7b. CITIZEN OF WHAT COUNTRY?	U S A		
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐			
9. COUNTY OF DEATH	Wicomico Md.		
10. CITY OR TOWN OF DEATH	Salisbury		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Pen.Gen.Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	House Wife		
12b. KIND OF BUSINESS OR INDUSTRY	None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY Wicomico	
13c. CITY OR TOWN	Salisbury		
13d. INSIDE CITY LIMITS? YES ☐ NO ☒			
13e. STREET AND NUMBER	R.D.# 1 (Shad Point)		
14. FATHER'S NAME First	CHARLES	Middle T.	Last HUTCHINS
15. MOTHER'S MAIDEN NAME First	ALICE	Middle G.	Last STERLING
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO.			
17. INFORMANT Address	Mr.John C.Andrews(Son) R.D.# 1 Shad Point - Salisbury, Maryland 21801		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic pulmonary emphysema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Long time
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) N/A
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) N/A	21f. LOCATION Street or R.F.D. No. City or Town County State N/A

22a. **I certify** that (I) (this hospital) attended the deceased from 5-23, 1969, to 5-28, 1969, that (I) (we) last saw the deceased alive on ____, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Willem R Ellis Jr.	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED	5-31-69				
22d. PHYSICIAN'S NAME (Type)	Dr.Wilbur R.Ellis Jr.	22e. ADDRESS	Medical Center-Salisbury, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	1 Jun.69	Shad Point Cemetery	Wicomico Co. Maryland	
24. FUNERAL DIRECTOR	ADDRESS	25a. REGD. BY REGISTRAR DATE	25b. FUNERAL DIRECTOR'S SIGNATURE	
HOLLOWAY & COMPANY	SALISBURY, MARYLAND	JUN 3, 1969		

VR A15 (1) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07624 07616

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MAY	MILLS	BAILEY	5	25	1969	8:20 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	5-11-1881	88 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	WIDOWED [X]	Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	House Wife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Hebron	YES [X] NO [ ]	Bradley& Smith Sts.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Isaac		Mills	Charlotte		Jenkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	———	219-07-6234	Mr. Edwin Bailey, Crooked Oak Lane Rt.#5	Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pancreatitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3-8 days
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5770
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH ~~OPERATION WAS~~ PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended ~~the~~ deceased from 5 20, 1969, to 5 25, 1969, that (I) (we) last saw the deceased alive on 5 25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
H. A. Boiele		[X]	[ ]	[ ]	5-26-1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
H. A. Boiele	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-28-1969	Wicomico Memorial Park	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hill Funeral Home Salisbury, Maryland	MAY 29 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07625 07617

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Denard	Jackson	Baker	May 29 1969	9:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	Oct. 24, 1896	72 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Berlin Md	U.S.A.	WIDOWED [X]	Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Deer's Head Hosp.	DRIVER	SOIL

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Worcester	Ocean City	YES [ ] NO [ ]	Golf Course Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ELIJAH		BAKER	ELLA	POINTER	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
YES WW I		MRS. ROBERT BARRATT OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adenocarcinoma of left kidney — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 months

189.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that [X] (this hospital) attended the deceased from May 19, 1969, to May 29, 1969, that [X] (we) last saw the deceased alive on May 29 1969, and that in [X] (our) opinion death occurred on the date and hour and from the causes stated above, (I) [X] (did) [ ] view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
C. H. Winnacott, M.D.	ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	6/2/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
C. H. Winnacott, M. D.	Deer's Head Hospital; Salisbury, Md. 21801

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	5/31/69	EVERGREEN	BERLIN WOR MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Anna A. Burbage	Berlin Md	JUN 5 1969	Charles Judge

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07626 — 07618

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First CHARLES Middle GERHARDT Last BELLMAN
2a. DATE OF DEATH: Month MAY Day 25 Year 1969
2b. HOUR: 11:15 M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: Jan 20 1884
6. AGE (In years last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Germany
7b. CITIZEN OF WHAT COUNTRY?: Germany
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Farmer
12b. KIND OF BUSINESS OR INDUSTRY: Farm
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: Sussex
13c. CITY OR TOWN: Delmar
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 400 Chestnut St.
14. FATHER'S NAME: First unknown Middle Last
15. MOTHER'S MAIDEN NAME: First unknown Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 214-28-8624
17. INFORMANT: Address: Frank Bailey Delmar, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lymphocytic Leukemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
2049

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased, from June, 1967, to MAY 25, 1969, that (I) ~~(saw)~~ last saw the deceased alive on MAY 25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated obave, (I) ~~(saw)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: Thomas C. Hill Jr. M.D. DEGREE — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 5-25-69
22d. PHYSICIAN'S NAME (Type): THOMAS C. HILL, Jr. M.D.
22e. ADDRESS: Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5/28/69
23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope
23d. LOCATION (City or Town) (County) (State): Delmar Sussex Del

24. FUNERAL DIRECTOR: William S. Moore
ADDRESS: Delmar Del
25a. RECD BY REGISTRAR DATE: MAY 29 1969
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A45 (2)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07627 — 07619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	W. SCOTT BOZMAN	2a. DATE OF DEATH Month Day Year	MAY 29, 1969
2b. HOUR	M		
3. SEX	MALE	4. RACE	WHITE
5. DATE OF BIRTH	AUG. 15, 1886	6. AGE (In years last birthday)	82 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	SOMERSET	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	WICOMICO CO. Md.
10. CITY OR TOWN OF DEATH	SALISBURY	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	PENINSULA GENERAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life; never if retired)	RETIRED WATERMAN	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MD.	13b. COUNTY	SOMERSET
13c. CITY OR TOWN	CHAMP	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	
13e. STREET AND NUMBER			
14. FATHER'S NAME First / Middle / Last	ALONZO S. BOZMAN	15. MOTHER'S MAIDEN NAME First / Middle / Last	NORA A. SCOTT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
17. INFORMANT Address	MRS. THORNTON HITCH ALLEN, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Senile Emphysema
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 5/16, 1969, to 5/29, 1969 that (I) (we) last saw the deceased alive on 5/29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H Brittingham — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): H H Briele — 22e. ADDRESS: Medical Center Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	BURIAL	23b. DATE	6/1/1969	23c. NAME OF CEMETERY OR CREMATORY	ORIOLE CEMETERY
23d. LOCATION (City or Town) (County) (State)	ORIOLE, MD.				
24. FUNERAL DIRECTOR ADDRESS	LEVIN R. WILSON PRINCESS ANNE, MD.	25a. REC'D BY REGISTRAR DATE	JUN 5 1969	25b. REGISTRAR'S SIGNATURE	Charles Judge

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

07623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07620

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)	First: GREGORY	Middle: ALLEN	Last: BROMLEY	2a DATE KNOWN OF DEATH ESTIMATED ☐	Month: 5	Day: 25	Year: 69	2b HOUR: 8:25 P.M.
3 SEX: M	4 RACE: W	5 DATE OF BIRTH: 5-7-54	6 AGE (in years last birthday): 15 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month 5 Day 25 Year 69	2d HOUR: 9 P.M.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.					
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): student	12b KIND OF BUSINESS OR INDUSTRY: High School					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Md.	13b COUNTY: Worcester	13c. CITY OR TOWN: Salisbury	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER: RFD 4				
14 FATHER'S NAME: First George	Middle	Last: Bromley	15. MOTHER'S MAIDEN NAME: First Rosa	Middle	Last: Osterwalder			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO: Unknown	17 INFORMANT: George M. Bromley	ADDRESS: RFD 7 Salisbury Md.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Fractured cervical spine — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

X17.1

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month Day, Year: HOUR 8:25 PM 5-25-69	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): Passenger in auto involved in accident
21d INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street factory, office building, etc.): highway	21f. LOCATION Street or R.F.D. No: Route 12 City or Town: Snow Hill, Worcester, Md. County State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D

EXAMINER'S NAME (Type): Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md. ADDRESS (Street, city, town, or county)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: May 27, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: May 28, 1969	23c NAME OF CEMETERY OR CREMATORY: Olivet Cemetery	23d LOCATION (City or Town): Eden, Maryland (County) (State)	
24. FUNERAL DIRECTOR: Dennis Funeral Home	ADDRESS: Snow Hill, Md.	25a RECD BY REGISTRAR DATE: JUN 5 1969	25b REGISTRAR'S SIGNATURE: Florence Justice	

VR A15ME 15M 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

07629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07621

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First: WILLIAM	Middle: JOHN	Last: BROMLEY	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ]	Month: 5	Day: 25	Year: 1969	2b. HOUR: 8:25 P.M.	
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: 8-8-52	6. AGE (If years last birthday): 16 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 5 Day 25 Year 1969		2d. HOUR: 9 P.M.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md						
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): laborer	12b. KIND OF BUSINESS OR INDUSTRY: construction						
13a. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) STATE: Md.	13b. COUNTY: Worcester	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RFD 4					
14. FATHER'S NAME: First George	Middle	Last: Bromley	15. MOTHER'S MAIDEN NAME: First Rosa	Middle	Last: Osterwalder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: Unknown	17. INFORMANT: George M. Bromley	ADDRESS: R.F.D. #4, Salisbury, Md.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Fractured cervical spine — APPROX. MAX. INTERVAL BETWEEN ONSET AND DEATH: sudden

17.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR 8:25 P.M. 5-25-69	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Driver of auto involved in accident.	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Highway	21f. LOCATION Street or R.F.D. No.: Route 12	City or Town / County / State: Snow Hill, Worcester, Md.

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royer, M.D.

M.D. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED: May 27, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 28, 1969	23c. NAME OF CEMETERY OR CREMATORY: Oliver Cemetery	23d. LOCATION (City or Town): Eden	(County): Maryland (State)
24. FUNERAL DIRECTOR: Dennis Funeral Home	ADDRESS: Snow Hill, Md.	25a. REC'D BY REGISTRAR DATE: JUN 2 1969	25b. REGISTRAR'S SIGNATURE: Florence Judge	

VR A15ME (5) 10M - 1/69

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

07630

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07622

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form (PM2- Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) First: MARTHA	Middle: A.	Last: BROWN	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: 5-28-69 19
2b HOUR: 9:55 A M			
3 SEX: F	4 RACE: AA	5 DATE OF BIRTH: 12-9-04	6 AGE (In years last birthday): 64 YRS; IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN
2c DATE PRONOUNCED DEAD Month 5 Day 28 Year 19 69	2d HOUR: 9:55 A M		
7a BIRTHPLACE (State or foreign country): Md.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Domestic	12b KIND OF BUSINESS OR INDUSTRY:
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Wicomico	13c CITY OR TOWN: Sharptown	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e STREET AND NUMBER: (Rural)			
14 FATHER'S NAME First: Irving	Middle	Last: Brown	15 MOTHER'S MAIDEN NAME First: Bertie
Middle	Last: Hopkins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215-20-4370	17. INFORMANT ADDRESS: Oden Brown, Sharptown, Md.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — APPROX. INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [ ] NO [X]
21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X] Inquiry [X] and in my opinion death resulted from Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royer, M.D. M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town or county): 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED: June 2, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5-31-69	23c NAME OF CEMETERY OR CREMATORY: Sharptown Cemetery	23d LOCATION (City or Town) (County) (State): Sharptown, Wicomico, Md.	
24. FUNERAL DIRECTOR ADDRESS: Booker M. West, Salisbury, Md.	25a. REC'D BY REGISTRAR DATE: JUN 3 1969	25b REGISTRAR'S SIGNATURE: Charles Judge		

VR A15ME (5)
10M - 1/69

1

07631

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

4339

1. DECEASED NAME (Type or print)	First: WILLIAM	Middle: MARION	Last: BUTLER	2a. DATE OF DEATH: Month MAY Day 30 Year 1969	2b. HOUR: 7:45 P.M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: June 12, 1889	6. AGE (In years last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1013 Market Street	
14. FATHER'S NAME First: Rufus	Middle: Allen	Last: Butler	15. MOTHER'S MAIDEN NAME First: Sarah	Middle: --	Last: Pusey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service): --	16b. SOCIAL SECURITY NO.: 217-36-0429	17. INFORMANT: Mrs Mabel L. Butler	Address: Pocomoke City, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 da

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED White ☐ Not white ☐ at work ☐ at work ☐	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 5-29, 1969, to 5-30, 1969, that (I) (we) last saw the deceased alive on 5-30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. R. Ellis — DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: 6-11-69

22d. PHYSICIAN'S NAME (Type): W. R. ELLIS — 22e. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6-3-1969	23c. NAME OF CEMETERY OR CREMATORY: First Baptist	23d. LOCATION (City or Town) (County) (State): Pocomoke City - Wor. -Md.	
24. FUNERAL DIRECTOR: Robert N. Watson	ADDRESS: Pocomoke City, Md.	25a. RECD BY REGISTRAR DATE: JUN 16 1969	25b. REGISTRAR'S SIGNATURE: Wesley Judge	

Robert N. Watson

VR A 5 (4) 45M 4/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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07632

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07623

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b HOUR
CHARLES	THOMAS	CANNON	5-25-69 19	9 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	3 August 56	12 YRS.	9	22			MAY 25 69	9 PM

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH
Salisbury	U S A		Wicomico Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	D.O.A. Pen.Gen.Hospital	School boy	None

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Worcester	Snow Hill	YES [ ] NO [X]	Md. Route #12 (Snow Hill Rd

14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last	17 INFORMANT ADDRESS
EMMETT WILLARD CANNON, SR.	MARY FRANCES LIMING	Mrs. Mary F. Cannon (Mother) R.D. #2 Snow Hill Rd. Snow Hill, Maryland

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO
No	None

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 — DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Fractured cervical spine — APPROX. MAX. INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

X12.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	8:25 A.M. P.M. 5/25 1969	Passenger in auto involved in accident.

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. City or Town County State
	Highway	Route 12, Snow Hill, Worcester, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from. Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.

409 Camden Ave. Salisbury, Md. ADDRESS (Street, city, town, or county)

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED MAY 26/1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	29 May 1969	Mt Olive Church Cem.	Worcester Co., Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY, MARYLAND	MAY 28 1969	Charles Judge

VR A15(M) (5) 10M REV. 68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR ATSMEDIST
10M REV 1968

MARYLAND STATE DEPARTMENT OF HEALTH

07633 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07624

1. DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED	2b HOUR
PAUL	WAYNE	CANNON	☒ Month Day Year 5-25-69 19 ☐	9 P M

3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	30 May 1954	14 YRS	11	25			MAY 25 1969	9 P M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Salisbury, Md	U S A		Wicomico Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	D.O.A. Pen.Gen.Hospital	School boy	None

13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Worcester	Snow Hill	YES ☐ NO ☒	Md. Route#12 (Snow Hill Rd

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
EMMETT	WILLARD	CANNON, SR	MARY	FRANCES	LIMING

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT ADDRESS
No	None	Mrs. Mary F. Cannon (Mother) R.D.#2 (Md. Route#12) Snow Hill Rd Snow Hill, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Fractured skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — X121

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month Day, Year HOUR	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	8:25 PM 5/25 1969	Passenger in auto involved in accident

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. City or Town County State
	highway	Route 12, Snow Hill, Worcester, Md.

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D

EXAMINER'S NAME (Type) Dr. Earl L. Royer

ADDRESS (Street, city, town or county) 409 Camden Ave. Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: May 26 /1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	29 May 1969	Mt Olive Church Cem.	Worcester Co., Maryland

24. FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY SALISBURY, MARYLAND	MAY 28 1969	[signature]

1

07634

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07625

Item	Entry
1 DECEASED NAME (Type or print) First / Middle / Last	KATE HOWARD Cissel
2a. DATE OF DEATH Month Day Year	May 17 69
2b HOUR	3 10 AM
3 SEX	Female
4. RACE	White
5. DATE OF BIRTH	2-17-1895
6. AGE (In years last birthday)	74 YRS
IF UNDER 1 YEAR MONTHS DAYS / IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country)	Maryland
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Widowed
9. COUNTY OF DEATH	Wicomico Md
10 CITY OR TOWN OF DEATH	Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Peninsula General
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	House Wife
12b KIND OF BUSINESS OR INDUSTRY	Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	MARYLAND
13b. COUNTY	Wicomico
13c CITY OR TOWN	HebRON
13d INSIDE CITY LIMITS? YES ☒ NO ☐	Yes
13e STREET AND NUMBER	MAIN ST
14 FATHER'S NAME First Middle Last	W FRANK HOWARD
15. MOTHER'S MAIDEN NAME First Middle Last	LuLu LANGSDALE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	No
16b. SOCIAL SECURITY NO.	700-00-6625
17 INFORMANT Address	Mrs Wm. W. Smullen Pine Bluff Rd., Salisbury, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

	Cause	Approximate interval between onset and death
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	9 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): none

Item	Entry
19a. DATE OF OPERATION	
19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES ☐ NO ☒	No
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	
21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	
21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	
21f. LOCATION Street or R.F.D. No City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 5/16, 1969, to 5/17, 1969, that (I) (we) last saw the deceased alive on 5/16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

Item	Entry
22b SIGNATURE	Alberta Mattax Polin
DEGREE ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	Attending Phys
22c DATE SIGNED	5/17/69
22d. PHYSICIAN'S NAME (Type)	Alberta Mattax Polin
22e ADDRESS	707 Camden Ave. Salisbury, Wicomico, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify)	BURIAL
23b. DATE	5-19-1969
23c NAME OF CEMETERY OR CREMATORY	St. Philips Cemetery
23d LOCATION (City or Town) (County) (State)	Quantico Wic Md.
24. FUNERAL DIRECTOR ADDRESS	Hill Funeral Home Salisbury, Md
25a REC'D BY REGISTRAR DATE	MAY 21 1969
25b REGISTRAR'S SIGNATURE	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1319

VR A1 45M 69

1

-FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07635 — 07626

1. DECEASED NAME (Type or Print) First: George	Middle: J	Last: Clauss, Sr.	2a DATE OF DEATH KNOWN ☒ / ESTIMATED ☐ Month: 5 Day: 18 Year: 1969	2b HOUR: M		
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: Nov. 18, 1902	6 AGE (In years last birthday) 66 YRS. IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN	2c DATE PRONOUNCED DEAD Month: 5 Day: 18 Year: 1969	2d HOUR: 2,500 PM	
7a. BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md			
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Penninsula General	12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired): Contractor (ret.)	12b KIND OF BUSINESS OR INDUSTRY: self-emp.			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Anne Arundel	13c CITY OR TOWN: Glen Burnie	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 521 Crain Hwy., N.E.		
14. FATHER'S NAME First: William	Middle	Last: Clauss	15. MOTHER'S MAIDEN NAME First: Clara	Middle: Blausteiner	Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 218 14 6551	17. INFORMANT: Mrs. Minnie B. Clauss (wife)	ADDRESS: Same As #13			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☐
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip A Insley M.D
EXAMINER'S NAME (Type): Philip A. Insley
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county)
22b. DATE SIGNED: 5-18-69

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: May 22, 1969	23c NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial Park	23d LOCATION (City or Town) (County) (State): Glen Burnie, Maryland	
24 FUNERAL DIRECTOR: T. Singleton	ADDRESS: Singleton Funeral Home Glen Burnie, Maryland	25a RECD BY REGISTRAR DATE: MAY 23 1969	25b REGISTRAR'S SIGNATURE: Charles Yingling	

VR A15ME (5) 10M REV 1-68

07637

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07628

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: Alton; Middle: ; Last: Corbin	2a. DATE OF DEATH Month: MAY; Day: 3; Year: 69	2b. HOUR: 10 58 PM	
3. SEX: Male	4. RACE: C	5. DATE OF BIRTH: 7/20/1917	6. AGE (in years last birthday): 51 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Pen. Gen. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: None
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 112 First St.
14. FATHER'S NAME First: Nathan; Middle: ; Last: Corbin	15. MOTHER'S MAIDEN NAME First: Velia; Middle: ; Last: Spence		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): I. II	16b. SOCIAL SECURITY NO.	17. INFORMANT: Elizabeth Armwood	Address: 112 First St. Salis Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebrovascular hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2½ hrs
4/22
Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive cardiovascular Disease — 4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, not fy medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18.)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from 5-2, 1969, to 5-3, 1969, that (I) (we) last saw the deceased alive on 5-3 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John S Bulkeley M.D. DEGREE — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: 5-5-69

22d. PHYSICIAN'S NAME (Type): John Bulkeley, Ind — 22e. ADDRESS: Pine Bluff Road, Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/8/69	23c. NAME OF CEMETERY OR CREMATORY: W. Pocomoke Cemetery	23d. LOCATION (City or Town): W. Pocomoke (County): Somerset (State): Md.	
24. FUNERAL DIRECTOR: Alston F. Stewart	ADDRESS: Salis Md.	25a. RECD BY REGISTRAR DATE: MAY 12 1969	25b. REGISTRAR'S SIGNATURE: [illegible]	

VR A15 (2) 45M 4-68

1

07638

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

1. DECEASED NAME (Type or print) First	William	Middle James	Last Culver
2a. DATE OF DEATH Month Day Year	May 25 69	2b. HOUR	3:30 PM
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	Aug 16, 1902	6. AGE (In years last birthday)	66 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Md	7b. CITIZEN OF WHAT COUNTRY?	US
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH	Wicomico Md
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Peninsula General
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	Md	13b. COUNTY	Wicomico
13c. CITY OR TOWN	Delmar	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	106 Chesmut St		
14. FATHER'S NAME First / Middle / Last	William Culver	15. MOTHER'S MAIDEN NAME First / Middle / Last	Lillie Fitzgerald
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
17. INFORMANT	Helen Culver	Address	Delmar Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Myocardial Infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 5-24, 19 69 to 5-25, 19 69, that (I) (we) last saw the deceased alive on 5-25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Wilbur O Ellis	DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED 5-25-69
22d. PHYSICIAN'S NAME (Type)	Wilbur R. Ellis	22e. ADDRESS	Medical Center - Salisbury, Wicomico, Md

23a. BURIAL, CREMATION REMOVAL (Specify)	Burial	23b. DATE	5/29/69	23c. NAME OF CEMETERY OR CREMATORY	St. Stephen
23d. LOCATION (City or Town)	Delmar	(County)	Sussex	(State)	Del
24. FUNERAL DIRECTOR	Williams Mord	ADDRESS	Delmar Del	25a. RECD BY REGISTRAR DATE	MAY 29 1969
25b. REGISTRAR'S SIGNATURE	Blanche Judge				

VR A15
45M

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forworded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as o burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremotion, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

07639 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07630

1. DECEASED NAME (Type or Print)	First: THOMAS	Middle: R.	Last: DAVIS	2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐	Month: 5	Day: 14	Year: 19	2b. HOUR: 4:40 P M			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Nov. 12, 1968	6. AGE (In years last birthday) YRS.:	IF UNDER 1 YEAR MONTHS: 6	DAYS: 2	IF UNDER 24 HRS. HOURS:	MIN:	2c. DATE PRONOUNCED DEAD Month: 5	Day: 14	Year: 19 69	2d. HOUR: 4:40 P M
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md								
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): -------	12b. KIND OF BUSINESS OR INDUSTRY: -------								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? Yes ☐ No ☐	13e. STREET AND NUMBER: 124 Whitmore Terrace							
14. FATHER'S NAME First: Eugene	Middle: F.	Last: Davis	15. MOTHER'S MAIDEN NAME First: Carol	Middle: -	Last: Justice						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service): -------	16b. SOCIAL SECURITY NO: -------	17. INFORMANT: Eugene F. Davis	ADDRESS: 124 Whitmoor Terr., S.S., Md.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Fractured skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR 3:30 P.M. 5-14-69	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Passenger in auto involved in accident.
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): street	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Ocean City, Worcester, Md

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opin an death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: May 15, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 17, 1969	23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery	23d. LOCATION (City or Town): Washington,	(County):	(State): D. C.
24. FUNERAL DIRECTOR: Warner Pumphrey, Silver Spring, Md.	ADDRESS: 8434 Georgia Avenue	25a. RECD BY REGISTRAR DATE: MAY 20 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge		

1 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07640

CERTIFICATE OF DEATH

07631

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Springhill Sanitarium, Inc.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
d. STREET ADDRESS: 9th & BALT. AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Margaret — Middle: H. — Last: Dennis

4 DATE OF DEATH: Month: May — Day: 10 — Year: 1969

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: OCT. 25, 1885

9 AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY: SELF-EMP.

11. BIRTHPLACE (County & State or foreign country): BERLIN MD (WORCO)

12 CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: HORACE F HARMONSON

14. MOTHER'S MAIDEN NAME: VIRGINIA LINGO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): NO

16 SOCIAL SECURITY NO:

17 INFORMANT Address: MRS JOSHUA BUNTING OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardio vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last
404 X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from March, 1967, to 5-10-1969, that (I) (we) last saw the deceased alive on 5-7, 1969, and that death occurred at 12:45 P.M., from causes and on the date stated above

22a. SIGNATURE: Philip A. Tnsley — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 5-12-69

22c. PHYSICIAN'S NAME (Type): Philip A. Tnsley

22d. ADDRESS: 116 East Main St, Salisbury, Md

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: 5/13/69

23c NAME OF CEMETERY OR CREMATORY: BUCKINGHAM

23d LOCATION (City or Town) (County) (State): BERLIN WOR. MD

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin Md.

25a. REC'D BY REGISTRAR DATE: MAY 15 1969

25b REGISTRAR'S SIGNATURE

13 07641

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07632

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Ellis	A.	Dix	May	11	1969	12:25 PM

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Female	Negro	Oct. 14, 1896	72 YRS.				

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	Housewife	none

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Delaware	Sussex	Bridgeville	YES ☒ NO ☐	11 Church Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ulysses S.		Adams	Sarah E.		Adams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT	Address
no	none	Selden S. Dix	11 Church Street Bridgeville, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROX. MAX. INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	1 week.
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive Heart Failure	3 weeks.
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Heart Disease	Not Known

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Diabetes Mellitus.

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4/26/, 1969, to 5/11/, 1969, that (I) (we) last saw the deceased alive on 5/10/ 1969, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
					5-11-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	5-15-69	Mt. Pleasant	Preston		Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Howard C. Steen	Dover, Del.	MAY 15 1969	

VR A15 (4)
45M - 1 '69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-P 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH

07642 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07633

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)	First: RICHARD	Middle: LEE	Last: EUBANK	2a DATE KNOWN OF DEATH ESTIMATED [X]	Month: May	Day: 29	Year: 1969	2b HOUR: 2P M			
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: 8 Feb. 1951	6 AGE (in years last birthday): 18 YRS	IF UNDER 1 YEAR: MONTHS 3 DAYS 21	IF UNDER 24 HRS: HOURS MIN	2c. DATE PRONOUNCED DEAD: Month May Day 29 Year 69		2d HOUR: 7P M			
7a BIRTHPLACE (State or foreign country): Baltimore Md.	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Wicomico Md								
10 CITY OR TOWN OF DEATH: Quantico (Rural)	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Poplar Hill Labor Camp	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer	12b KIND OF BUSINESS OR INDUSTRY: None								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b COUNTY: X	13c CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 307 S. Stricker St.							
14 FATHER'S NAME: First EDWIN Middle BRYCE Last EUBANK	15. MOTHER'S MAIDEN NAME: First RUBY Middle Last SOWERS										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: Mother	ADDRESS: (Same as# 13e)								

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Drowning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. (P.M.) 2 (P.M.) 5-29 1969	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Swimming - [illegible]		
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e PLACE OF INJURY (At home, farm, street, factory office building, etc.) Nanticoke River	21f LOCATION Street or R.F.D. No. Poplar Hill	City or Town	County: Wicomico — State: Md

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Dr. Earl L. Royer

ADDRESS (Street, city, town, or county): 407 Camden Ave. Salisbury, Md

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: May 30 /1969

23a [illegible] REMOVAL (Specify) Burial	23b DATE: 30 May 1969	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State): Baltimore, Maryland	
24 FUNERAL DIRECTOR: HOLLOWAY & COMPANY	ADDRESS: SALISBURY, MARYLAND	25a RECD BY REGISTRAR: JUN 3 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07643 — 07634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A.5 45M 68

1. DECEASED NAME (Type or print)	First: John	Middle: Everett	Last: Figgs	2a. DATE OF DEATH Month: May Day: 11 Year: 1969	2b. HOUR: 8:15 a M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: May 25 1880	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 833 E. Church St	
14. FATHER'S NAME First: David Middle: [illegible] Last: Figgs	15. MOTHER'S MAIDEN NAME First: Mary Middle: [illegible] Last: Mott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 222-05-6029	17. INFORMANT: Bertie Figgs	Address: Salisbury Md	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c): Concussion

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 5-8, 1969, to 5-11, 1969, that (I) (we) last saw the deceased alive on 5-11 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. E. Smith DEGREE — ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 5-11-69

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 5/14/69	23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Cem	23d. LOCATION (City or Town): Delmar	(County): Sussex	(State): Del.
24. FUNERAL DIRECTOR: Willard Morris	ADDRESS: Delmar Del	25a. REC'D BY REGISTRAR DATE: MAY 14 1969	25b. REGISTRAR'S SIGNATURE		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07644

09119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 45M 1/68

1. DECEASED-NAME (Type or print): First Eliza Middle Sturgis Last Fooks
2a. DATE OF DEATH: Month May Day 29 Year 1969
2b. HOUR: 10 PM
3. SEX: F
4. RACE: Negro
5. DATE OF BIRTH: 2-11-1905
6. AGE (In years last birthday): 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Berlin
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE: Maryland
13b. COUNTY: Worc.
13c. CITY OR TOWN: Berlin
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Rt #2 Box 154
14. FATHER'S NAME First Robert Middle Lost Sturgis
15. MOTHER'S MAIDEN NAME First Eleanor Middle Lost Tingle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO: 213-24-1227
17. INFORMANT: Smith F. Skinner Address Rt #2 Box 154 Berlin Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4123
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 5-22, 1969, to 5-29, 1969, that (I) (we) last saw the deceased alive on 5-29 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wilber R. Ellis DEGREE ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 5-29-69
22d. PHYSICIAN'S NAME (Type): Wilber R. Ellis, Jr.
22e. ADDRESS: Medical Center - Salisbury, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-2-69
23c. NAME OF CEMETERY OR CREMATORY: Fooks
23d. LOCATION (City or Town) (County) (State): Berlin Worc. Md.

24. FUNERAL DIRECTOR: Jersey Rd. Jersey Funeral Home
ADDRESS: Salisbury Md.
25a. REC'D BY REGISTRAR DATE JUN 10 1969
25b. REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-68)
45M - 1/69

07645

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07635

1. DECEASED NAME (Type or print)	First: Baby	Middle: Boy	Last: FOREMAN	2a. DATE OF DEATH: Month MAY	Day 2	Year 1969	2b. HOUR 6:49 A.M.
3. SEX: MALE	4. RACE: Negro	5. DATE OF BIRTH: May 2, 1969	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN. 36		
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.				
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen. Gen. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY				
13a. U.S.A. RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: Md.	13b. COUNTY: Worcester	13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.F.D.			
14. FATHER'S NAME First: George	Middle	Last: Holland	15. MOTHER'S MAIDEN NAME First: Elizabeth	Middle	Last: Foreman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: George Holland	Address: Pocomoke Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Immature — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 m.

7701

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Partial Separation of Placenta & Hypoxia (Intra uterine)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒	22c. DATE SIGNED
Chan		5-6-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DAO CHAN	Peninsula General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-8-69	Wardtown Cem.	Pocomoke Wor. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Samuel Lewis	New Church Va.	MAY 9 1969	Deputy Judge

1
FOR STATE HEALTH DEPT.

07646

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07636

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)	First: RAYMOND	Middle: THOMAS	Last: FOREMAN	2a. DATE KNOWN ☒ OF DEATH / EST. ☐ Month: 5	Day: 25	Year: 69	2b. HOUR: 8:25 P M				
3 SEX: M	4 RACE: AA	5 DATE OF BIRTH: 4-8-24	6 AGE (In years last birthday): 45 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month 5	Day 25	Year 69	2d HOUR: 9 P M		
7a BIRTHPLACE (State or foreign country): Berlin	7b CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md								
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	20. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer	12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Md.	13b. COUNTY: Worcester	13c. CITY OR TOWN: Berlin	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: Rt. 3, Box 236E							
14. FATHER'S NAME First: Annoris	Middle	Last: Foreman	15. MOTHER'S MAIDEN NAME First: Elsie	Middle	Last: Parker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, Navy (If yes give war or dates of service) W.W. II	16b. SOCIAL SECURITY NO: 213-24-0152	17. INFORMANT: Alice Foreman	ADDRESS: Rt #3 Box 236E Berlin Md								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Fractured skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR 8:25 AM ☒ PM ☐ 5-25-69	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Involved in auto accident.
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway	21f. LOCATION Street or R.F.D. No. Route 12 / City or Town Snow Hill / County Worcester / State Md.

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED: May 27, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-28-69	New Bethel	Berlin, Worcester, Md.

24. FUNERAL DIRECTOR / ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Jolley Funeral Home, Salisbury, Md.	JUN 2 1969	

VR A15ME (8)
10M 1/69

8/59

1

07647

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07637

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First BESSIE Middle MAE Last GILLIS
2a. DATE OF DEATH: Month MAY Day 22 Year 1969
2b. HOUR: 5:45 M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Aug 30, 1892
6. AGE (In years last birthday): 76 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Del
7b. CITIZEN OF WHAT COUNTRY?: US
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housework
12b. KIND OF BUSINESS OR INDUSTRY: Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Del
13b. COUNTY: Susex
13c. CITY OR TOWN: Delmar
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 605 E State St.
14. FATHER'S NAME First George Middle Last Dykes
15. MOTHER'S MAIDEN NAME First Mary Middle Last Owens
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service): —
16b. SOCIAL SECURITY NO: 221-32-9584
17. INFORMANT: William H. Gillis Address: Delmar Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 da
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 5-8, 1969, to 5-22, 1969, that (I) (we) last saw the deceased alive on 5-22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. O. Gillis DEGREE: ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 5-22-69
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE: 5/24/69
23c. NAME OF CEMETERY OR CREMATORY: St. Stephens
23d. LOCATION (City or Town) (County) (State): Delmar Sussex Del
24. FUNERAL DIRECTOR: William Mervel ADDRESS: Delmar Del
25a. REC'D BY REGISTRAR DATE: MAY 23 1969
25b. REGISTRAR'S SIGNATURE: Witness my Judge

VR A15 (M)
45M 1-69

1

07643

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07638

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Evelyn	Malissa	GODWIN	MAY	25	1969	9:45 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
FEMALE	WHITE	April 2,1902	67 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Va.	USA		Wicomico Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	Labor	Basket

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Wicomico	Salisbury	YES ☒ NO ☐	421 Race Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles		Marshall	Mary		Spence

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Franklin L. Godwin	Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Mesenteric artery thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk

444.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 5/15, 1969, to 5/25, 1969, that (I) (we) last saw the deceased alive on 5/25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED
Thos. Wallace			5/26/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-28-1969	Cape Charles Cem.	Cape Charles, Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Thomas F. Wallace	Thomas F. Wallace, Salisbury, Md.	MAY 29 1969	Wilmer Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 45M 1-69

07649

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07639

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR	
Rosa	Downs	Guthrie	May	3	69	7:10A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	7-8-1878	90 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH				
Maryland	U.S.A.		Wicomico Md				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury	Deer's Head St.	House Wife	Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER			
Maryland	Wicomico	Salisbury		John B. Parsons Home			
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last		
Joesph		Downs	Emeline		Powell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address			
No	—	Unknown	John B. Parsons Home, Salisbury, Maryland				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Pulmonary Embolus - 14-16 Days — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

41

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arterio Sclerotic Cardiovascular Disease-Years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Old CVA - Left Hemi Paresis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11/16, 1964, to 5/3, 1969, that (I) (we) last saw the deceased alive on 5/3 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS. ☑	22c. DATE SIGNED
C.H. Wincecott					5/8/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. C.H. Wincecott	Deer's Head, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-6-1969	Parsons Cemetery	Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hill Funeral Home Salisbury, Maryland	MAY 6 1969	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07650

CERTIFICATE OF DEATH

07640

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b. HOUR
Brice	Mace	HALL	May	22	1969	6:30 A M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
MALE	White	June 14, 1899	69 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	U.S.		Wicomico Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	Rural Mail carrier,	

13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Dorchester	Cambridge	YES ☒ NO ☐	315 Maryland Ave.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Robert	H.	Hall	Amanda		Ford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
Yes	WW1 & WW2		Mrs. Brice Hall	Same as #13

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Suffocation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonitis + Atelectasis — 10 days.

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis — years.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
	Inguinal Hernia	YES ☒ NO ☐	Yes.

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 5-18, 1969, to 5-21, 1969, that (I) (we) last saw the deceased alive on 5-21-69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

22b SIGNATURE	DEGREE			22c DATE SIGNED
Joseph C. Fitzgerald	M.D.	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS		

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/25/1969	Greenlawn Cmetery	Cambridge Dorchester Md.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Kenneth L. Hearn Jr.	Cambridge Md. 21613	DATE MAY 29 1969	Charles Judge

VR A15 (1-69)
45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07651 — 07641

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First / Middle / Last	Olive Payne Hancock	2a. DATE OF DEATH Month Day Year	May 8 1969
2b. HOUR	2:18 PM		
3. SEX	Female	4. RACE	Caus
5. DATE OF BIRTH	11-01-85	6. AGE (In years last birthday)	83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Md	7b. CITIZEN OF WHAT COUNTRY?	U.S.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐		9. COUNTY OF DEATH	Wicomico Md.
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Wicomico Nursing Home — Booth St, Salisbury Md
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Housewife	12b. KIND OF BUSINESS OR INDUSTRY	Private Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	Md	13b. COUNTY	Worcester
13c. CITY OR TOWN	Snow Hill	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	
13e. STREET AND NUMBER	102 N. Washington St.		
14. FATHER'S NAME First / Middle / Last	William H. Payne	15. MOTHER'S MAIDEN NAME First / Middle / Last	Sarah E. Hancock
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	No	(If yes give war or dates of service)	—
16b. SOCIAL SECURITY NO	220-44-5392	17. INFORMANT Address	William S. Hancock, Snow Hill Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Pulmonary edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

2504

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral A. thrombosis — 10 mos

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes — 4 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 11-8, 1968, to 5-8, 1969, that (I) (we) last saw the deceased alive on 5-7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death

22b. SIGNATURE	[signature] MD	DEGREE	ATTENDING PHYS ☑	MED DIRECTOR ☐	STAFF PHYS ☐
22c. DATE SIGNED	5/12/69				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	May 10, 1969	
23c. NAME OF CEMETERY OR CREMATORY	Bates Meth.	23d. LOCATION (City or Town) (County) (State)	Snow Hill Md.	
24. FUNERAL DIRECTOR	Lemmon & Mumford	ADDRESS	Snow Hill, Md.	
25a. REC'D BY REGISTRAR DATE	MAY 14 1969	25b. REGISTRAR'S SIGNATURE		

VR A15 45M - 1-68

1

07652

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07642

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First **MARY** Middle **HARRIS** Last **HANDY**

2a. DATE OF DEATH: Month **May** Day **17,** Year **1969**

2b. HOUR: **4:50PM**

3. SEX: **Female**

4. RACE: **Colored**

5. DATE OF BIRTH: **11/15/96**

6. AGE (In years last birthday): **73** YRS

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN

7a. BIRTHPLACE (State or foreign country): **Md**

7b. CITIZEN OF WHAT COUNTRY?: **U.S.A.**

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: **WICOMICO** Md.

10. CITY OR TOWN OF DEATH: **Salisbury**

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): **Deer's Head State Hospital**

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): **Domestic**

12b. KIND OF BUSINESS OR INDUSTRY:

13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: **Maryland**

13b. COUNTY: **Talbot**

13c. CITY OR TOWN: **Queen Anne**

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET AND NUMBER: **Rt. #2**

14. FATHER'S NAME First **John** Middle **Harris** Last

15. MOTHER'S MAIDEN NAME First **Mary** Middle **Kimmon** Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown

(If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: **220-03-5318**

17. INFORMANT: **John Handy** Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): **Recurrent cerebral vascular accident** — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: **48 hrs**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): **Essential hypertension** — **Years**

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Cerebral vascular accident with right hemiplegia, 2/2/69

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from **March 17** , 19 **69** , to **May 17** , 19 **69** , that ~~I~~ (we) last saw the deceased alive on **May 17,** 19 **69** and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: **C. H. Winnacott, M.D.** DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22c. DATE SIGNED: **5/19/69**

22d. PHYSICIAN'S NAME (Type): **C. H. Winnacott, M. D.**

22e. ADDRESS: **Deer's Head State Hospital, Salisbury, Maryland**

23a. BURIAL, CREMATION, REMOVAL (Specify): **Burial**

23b. DATE: **5/20/69**

23c. NAME OF CEMETERY OR CREMATORY: **Newtown Cem**

23d. LOCATION (City or Town) (County) (State): **Queen Anne Md**

24. FUNERAL DIRECTOR: **George H. Dashiell**

ADDRESS: **Eden Md**

25a. RECEIVED BY REGISTRAR DATE: **MAY 21 1969**

25b. REGISTRAR'S SIGNATURE: **Wendell Jones**

VR A15 45M

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07653 07643

1. DECEASED-NAME (Type or Print)	First: LAWRENCE	Middle: WILLIAM	Last: HINMON	2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month: 5 Day: 18-69 Year: 19				2b HOUR: 3:40 A M		
3 SEX: Male	4. RACE: AA	5 DATE OF BIRTH: 12-20-35	6. AGE (In years last birthday): 33 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 5 Day: 18 Year: 1969		2d HOUR: 4:10 A M		
7a. BIRTHPLACE (State or foreign country): Va.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.							
10 CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): laborer	12b KIND OF BUSINESS OR INDUSTRY: factory work							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Va.	13b COUNTY: Accomack	13c CITY OR TOWN: Withams	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER						
14 FATHER'S NAME First: Edward	Middle	Last: Hinmon	15 MOTHER'S MAIDEN NAME First: Addie	Middle	Last: Corbin					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 230-42-5082	17 INFORMANT: Mrs. Addie Lewis (mother)	ADDRESS: Withams Va.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Crushed chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.: 3:40 xx 5-18-69	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18): Pedestrian struck by automobile.

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.): highway, Rt. 113,	21f LOCATION Street or R.F.D. No / City or Town / County / State: 3 mi. so. of Snow Hill, Worcester, Md.

22a **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X] Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street city, town, or county): 409 Camden Ave., Salisbury, Md

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: May 19, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): burial	23b DATE: 5-24-69	23c. NAME OF CEMETERY OR CREMATORY: Massongo Cemetery	23d LOCATION (City or Town) (County) (State): McKinley Park Va.

24 FUNERAL DIRECTOR / ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Wharton & Savage, New Church, Va.	MAY 23 1969	Charles Judge

VR A15ME (5)
10M REV 1/68

1
FOR STATE HEALTH DEPT.

07654

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07644

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ME-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1 DECEASED NAME (Type or Print) First	Middle	Last
Lester	Marion	Holloway

2a DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR
☒	5	29	1969	1:00 A.M.

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN
Male	White	Oct. 12, 1926	42 YRS	7	17		

2c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR
May	29	1969	9:00 A.M.

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Hebron, Wicomico Co., Md.	U.S.A.	NEVER MARRIED ☒	Wicomico Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	S. Park Dr. & Schumaker Rd.	Salesman	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES ☐ NO ☐	302 Glendale Dr.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Marion	Sidney	Holloway	Ruth		Rector

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
Yes W.W. II	213-22-8168	Mrs. Mildred D. Holloway, wife,	302 Glendale Dr. Salisbury, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carbon monoxide poisoning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR A.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	1 XX 5-29 19 69	Self inflicted, auto exhaust.

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State
	street	S. Park Dr. & Schumaker Rd.,	Salisbury,	Wic.,	Md.

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D

EXAMINER'S NAME (Type) Dr. Earl L. Royer

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 30, 1969	Springhill Mem. Gardens	Salisbury, Wicomico, Md.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Holloway & Company, Salisbury, Maryland	JUN 6 1969	Charles Jones

VR A15ME (5)
10M 1-69

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

07655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07645

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	Month Day Year	2b HOUR
FRANKLIN	P.	HORNER	X / ☐	5-20-69 19	3:09 P M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last Birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	W	8-1-48	20 YRS			5 20 69	3:55 P M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED X WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Md.	U.S.A.		Wicomico Md.

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	laborer	

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Wicomico	Bivalve	YES ☐ NO ☐	

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Roy	Levin	Horner	Stella	Ann	Nezin

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No	216-56-1281	Clarence Nonez	Tyaskin, Md.

MED.CAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Fractured skull

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO X

21a EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR AM X PM	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	3:09 5-20-69	Driver of auto involved in accident.

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No / City or Town / County / State
	highway, Rt. 349	Quantico Rd., Salisbury, Wic., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md

22b DATE SIGNED: May 22, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
burial	5-23-69	Bivalve Cemetery	Bivalve, Wicomico, Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Messick Funeral Home, Bivalve, Md.	NOV 26 1969	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M 1 69

8150

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07656

CERTIFICATE OF DEATH

07646

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b. HOUR
EDWARD	LEE	HUDSON	5	18	1969	3:A M

3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	Dec.6,1930	38 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U.S.A.		Wicomico Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Daisey Lee Nursing Home	Alumnium Siding	Applier

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER
Maryland	Wicomico	Salisbury		Spring Hill Rd., Rt.#5

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Samuel	J	Hudson	Daisey		Ward

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	Koren	220-26-3889	Mrs. Beulah C. Hudson, See Sec.13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY.

		APPROX MATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic Heart Disease. Typ	
DUE TO, OR AS A CONSEQUENCE OF (b)	(with myocardial infarctions)	
DUE TO, OR AS A CONSEQUENCE OF (c)		

1109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Ventricular Aneurysm

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 4-24, 1969, to 5-18, 1969, that (I) (we) last saw the deceased alive on 5-17-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE	DEGREE	22c DATE SIGNED
David J. Gilmore	ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]	5-20-1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. David J. Gilmore	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-21-1969	St.Hill MemoreyGardens	Hebron, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hill Funeral Home Salisbury Maryland	MAY 21 1969	Beverly Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 68

1

07657

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First: MARY	Middle: VIRGINIA	Last: Humphreys	2a. DATE OF DEATH Month: MAY Day: 28 Year: 69	2b. HOUR: 1:45 AM	
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: 19 July 1902	6 AGE (In years last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Worcester Co. Md.	7b. CITIZEN OF WHAT COUNTRY?: U S A	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md		
10. CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a USUAL OCCUPATION (Kind of work done during most of work life even if retired): House Wife	12b KIND OF BUSINESS OR INDUSTRY: None		
13a. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: R.D.#5	
14 FATHER'S NAME First: ROBERT	Middle: J.	Last: ATKINSON	15 MOTHER'S MAIDEN NAME First: MARY	Middle: ELIZABETH	Last: MADDOX
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT (Address): Mr. Howard T. Humphreys (Husband) R.D.# 5 Salisbury, Maryland		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4 1 d 2
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive & Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): N/A	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: N/A	

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from 5-21, 19 67, to 5-28, 19 69, that (I) (~~we~~) last saw the deceased alive on 5-27-1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: James L. Clifford DEGREE — ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: 5/28/69

22d. PHYSICIAN'S NAME (Type): JAMES L. CLIFFORD M.D. — 22e. ADDRESS: MEDICAL CENTER - SALISBURY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 30/1969	23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland	
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY	ADDRESS: SALISBURY, MARYLAND	25a. RECD. BY REGISTRAR DATE: JUN 3 1969	25b. REGISTRAR'S SIGNATURE	

VR A15 (4) 45M - 1/69

1
FOR STATE HEALTH DEPT.

07658

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07648

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)	First: JOHN	Middle: E.	Last: HURT	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐	Month: 5	Day: 25	Year: 1969
2b HOUR: 2 P M							
3 SEX: Male	4 RACE: AA	5 DATE OF BIRTH: Aug. 20, 1897	6 AGE (In years last birthday): 71 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month 5 Day 25 Year 1969	2d HOUR: 9:35 A M
7a. BIRTHPLACE (State or foreign country): Carolina	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.				
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): minister	12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Penn.	13b COUNTY	13c CITY OR TOWN: Delta	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER			
14 FATHER'S NAME First: Unknown	Middle	Last	15 MOTHER'S MAIDEN NAME First: Unknown	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): W.W.I	16b SOCIAL SECURITY NO.	17. INFORMANT: Lucille Hurt	ADDRESS: 925 Camp St. Indianapolis			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Hypertensive cardio-vascular disease

DUE TO, OR AS A CONSEQUENCE OF

(c):

4122

Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No / City or Town / County / State

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M D

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: May 26, 1969

23a. BURIAL, CREMATION REMOVAL (Specify): Burial	23b DATE: 5/29/69	23c NAME OF CEMETERY OR CREMATORY: Green Acress	23d LOCATION (City or Town) (County) (State): Salisbury Wicomico Md.	
24. FUNERAL DIRECTOR: Clinton Stewart	ADDRESS: Clinton Stewart, Salisbury, Md.	25a. RECD BY REG STRAR DATE: JUN 4 1969	25b REG STRAR'S SIGNATURE: Charles Judge	

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07659 07649

1 DECEASED NAME (Type or Print)	First: ROSA	Middle: MAE	Last: JACKSON	2a DATE KNOWN OF DEATH [X] EST. MATED [ ]	Month Day Year: 5-11-69 19	2b HOUR: 5:10 A M
3 SEX: F	4. RACE: AA	5. DATE OF BIRTH: 9-1-32	6 AGE (In years last birthday): 36 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month 5 Day 11 Year 1969	2d HOUR: 5:10 A M
7a BIRTHPLACE (State or foreign country): Va	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md				
10. CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer	12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Worcester	13c CITY OR TOWN: Berlin	13d INSIDE CITY LIMITS? YES [ ] NO [ ]	13e STREET AND NUMBER: P.O. Box 35			
14 FATHER'S NAME First Middle Last: Richard Weaver	15 MOTHER'S MAIDEN NAME First Middle Last: Rosa Lee James						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 264-54-7448	17. INFORMANT: Agnes Weaver	ADDRESS: Mansfield, Ohio 372 Exchange St.				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Rupture of the uterus, spontaneous during

DUE TO, OR AS A CONSEQUENCE OF (b): delivery, full term — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 50 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A M P M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.

22b. DATE SIGNED: May 13, 1969

23a BURIAL, CREMATION REMOVAL (Specify): BURIAL	23b DATE: 5-17-69	23c NAME OF CEMETERY OR CREMATORY: Mansfield	23d LOCATION (City or Town): Mansfield	(County) (State): Ohio
24. FUNERAL DIRECTOR: Jolley Funeral Home, Salisbury, Md.	ADDRESS	25a REC'D BY REGISTRAR DATE: MAY 19 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

VR A15ME (5)
10M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07660

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07650

1. DECEASED-NAME (Type or Print) First	Middle	Last
NELIUS	JAMES	JOHNSON

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month 5 Day 5 Year 69 — 2b. HOUR 1110 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.
M	AA	6-1-54	14 YRS				

2c. DATE PRONOUNCED DEAD Month 5 Day 5 Year 69 — 2d. HOUR 3 P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Wicomico	U S A		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Rockawalkin Road	student	None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Wicomico	Salisbury	YES ☐ NO ☐	Crooked Oak Lane

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Cornelius	J.	Johnson	Estelle		Lawrence

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Never	None	Cornelius Johnson	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Drowning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
7100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR AM PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)
	1 PM 5-5-69	Sank while swimming in sand hole.

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	swimming hole, off	Rockawalkin Road,	Salisbury,	Wic.,	Md.

22a. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D.

EXAMINER'S NAME (Type) Earl L. Royer, M.D. — ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED May 6, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-10-69	Fuentes Cem	Fuentes Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Booker West,	Salisbury, Md.	MAY 8 1969	

VR A15ME (5) 10M REV 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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07661

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07651

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
	SAMUEL	ROOSEVELT	JOHNSON	☒ / ☐	5	13	69	10:10 AM

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN	2c DATE PRONOUNCED DEAD: Month	Day	Year	2d HOUR
Male	AA	5-10-25	44 YRS					5	13	1969	10:10 AM

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Quantico	U.S.A		Wicomico Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	LABORER	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Wicomico	Quantico	YES ☐ NO ☐	Route 1, Box 4

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
George		Johnson	Emma		Fortune

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
		Marguerite Johnson	Rt #1 Box 4 Quantico, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Crushed chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

"17.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR AM ☒ PM	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	9:45 PM 5-13-69	Driver of auto involved in accident.

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	highway	Rt. 353	Quantico Rd.,	Salisbury,	Wicomico, Md.

22a I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

409 Camden Ave., Salisbury, Md. ADDRESS (Street, city, town, or county)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: May 15, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5-17-69	Mt. Zion	Quantico Wico Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Jolley Funeral Home, Salisbury, Md.	MAY 21 1969	Charles Judge

VR A15ME (5) 10M REV 1/68

1

07662

Item6 Film6412 5/16/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07652

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: CHARLOTTE	Middle:	Last: JOLLY	2a. DATE OF DEATH Month: MAY Day: 3 Year: 1969	2b. HOUR: 10:25 PM	
3 SEX: FEMALE	4 RACE: Negro	5 DATE OF BIRTH: July 19 04	6 AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Wicomico	7b. CITIZEN OF WHAT COUNTRY? U S A	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Wicomico Md		
10 CITY OR TOWN OF DEATH: SALISBURY	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b KIND OF BUSINESS OR INDUSTRY: None		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md	13b COUNTY: Wicomico	13c CITY OR TOWN: Shepherdtown	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: R.D.	
14. FATHER'S NAME First: Leonard	Middle:	Last: Hopkins	15 MOTHER'S MAIDEN NAME First: Martha	Middle:	Last: Fowler
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b SOCIAL SECURITY NO:	17 INFORMANT: Joseph Jolly	Address:		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Severe Left Ventricular Cardiomegaly — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO, OR AS A CONSEQUENCE OF

(b): Hypertensive Cardiovascular Disease — ???

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO OR AS A CONSEQUENCE OF

(c): Hypertension — ?

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from Apr 28, 1969, to May 3, 1969, that (I) (we) last saw the deceased alive on May 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: G. Herbert Semply MD	DEGREE: ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22c DATE SIGNED: 5/3/69	
22d PHYSICIAN'S NAME (Type): G. Herbert Semply MD	22e ADDRESS: Salisbury Md 21801		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5-6-69	23c NAME OF CEMETERY OR CREMATORY: Parkview	23d LOCATION (City or Town) (County) (State): Shepherdtown Wicomico Md	
24. FUNERAL DIRECTOR: Dorsey	ADDRESS: Salisbury Md	25a RECD BY REGISTRAR: MAY 13 1969	25b REGISTRAR'S SIGNATURE: Charles Dodge	

VR A15 45M 1/69

4

1

FOR STATE HEALTH DEPT.

07663

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07653

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1 DECEASED NAME (Type or Print) First: CLAYTON	Middle: OLIVER	Last: JONES	2a DATE OF DEATH KNOWN ☑ ESTIMATED ☐ Month Day Year: 5-25-69 19	2b HOUR: 8:50 P M		
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: 6-13-1893	6 AGE (In years last birthday) 75 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 5 Day 25 Year 1969	2d HOUR: 8:50 P M	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Wicomico Md			
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY			
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Worcester	13c CITY OR TOWN: Pocomoke	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER: Rt. 2		
14 FATHER'S NAME First: Marion	Middle: Harris	Last: Jones	15 MOTHER'S MAIDEN NAME First: Clementine	Middle: Maloy	Last: Redden	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W.W. I	16b SOCIAL SECURITY NO: 217-36-1049	17 INFORMANT (nephew) ADDRESS: Richard E. Jones, Rt. 3, Pocomoke, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cerebral hemorrhage, spontaneous — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic cardio-vascular disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4124

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D

EXAMINER'S NAME (Type): Earl L. Royer, M.D. ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: May 26, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): burial	23b DATE: 5-28-69	23c NAME OF CEMETERY OR CREMATORY: Goodwill Methodist	23d LOCATION (City or Town) (County) (State): Pocomoke, Wor., Md.	
24 FUNERAL DIRECTOR ADDRESS: Robert N. Watson Robert H. Watson, Pocomoke, Md.	25a REC'D BY REGISTRAR DATE: MAY 29 1969	25b REGISTRAR'S SIGNATURE: J. Charles Judge		

VR A15M (5) 10M - 4-69

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07664

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: CORNELIA	Middle: G.	Last: JONES	2a. DATE OF DEATH Month: May Day: 20 Year: 1969	2b. HOUR: M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: February 19, 1883	6. AGE (In years last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: WICOMICO Md	
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.D. 6, Dagsboro Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: --	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: R.D. 6, Dagsboro Road
14. FATHER'S NAME First: Elisha	Middle:	Last: Givan	15. MOTHER'S MAIDEN NAME First: Elizabeth	Middle: Last: Parsons
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 219-46-4497	17. INFORMANT (Daughter): Mrs. Hazel J. Nepert	Address: 3210 Ocean City Rd., Salisbury, Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from June, 19 67, to May, 19 69, that (I) (we) last saw the deceased alive on 4/24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alberta Mattax Polin DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: May 22 /1969		
22d. PHYSICIAN'S NAME (Type): Dr. Alberta Mattax Polin	22e. ADDRESS: 707 Camden Avenue, Salisbury, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 23, 1969	23c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cemetery	23d. LOCATION (City or Town) (County) (State): R.D., Willards, Maryland	
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND	ADDRESS	25a. RECD BY REGISTRAR DATE: MAY 26 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A[illegible] 45M - [illegible]69

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07665

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07655

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: HAZEL	Middle: MARIE	Last: JONES	2a. DATE OF DEATH Month Day Year: May 21, 1969	2b HOUR: 7:55A M
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: December 3, 1891	6 AGE (In years last birthday): 77 YRS.	UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): Ohio	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: WICOMICO		Md
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b KIND OF BUSINESS OR INDUSTRY: =		
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE: Maryland	13b COUNTY: Caroline	13c CITY OR TOWN: Greensboro	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e STREET AND NUMBER: Eglantine Farms, Inc.	
14. FATHER'S NAME First: Jonas	Middle	Last: Hampshire	15. MOTHER'S MAIDEN NAME First: Dora	Middle	Last: Zeigler
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 217-10-3929	17 INFORMANT: (Son)	Address: R.D. 1 Mr. Paul W. Jones, Greensboro, Maryland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Carcinoma of ovary with wide spread metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Mar. '68

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Parkinson's disease

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from October 7, 1968, to May 21, 1969, that (I) (we) last saw the deceased alive on May 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: A. C. Mitchell — DEGREE: ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒ — 22c DATE SIGNED: 5/21/69

22d. PHYSICIAN'S NAME (Type): A. C. Mitchell, M. D. — 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: May 24, 1969	23c NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park	23d LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland	
24 FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND	ADDRESS	25a RECD BY REGISTRAR DATE: MAY 26 1969	25b REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (1)
45M - 7/68

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07666

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07656

1. DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b. HOUR
Thomas	James	Jones	May	25	1969	2:40 p

3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
male	negro	Dec. 8, 1911	57 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Maryland	U.S.A.		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Pine Bluff State Hosp.	Laborer	-

13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	344 Delaware Ave.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Isaac	James	Jones	Bertha	-	Milbourne

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT	Address
No	-	220-10-9767	records of	Pine Bluff State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, F.A. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a I certify that (I) (this hospital) attended the deceased from May 6, 1969, to May 25, 1969, that (I) (we) last saw the deceased alive on May 25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☒	STAFF PHYS ☐	22c DATE SIGNED
E. P. Ritchings					May 26, 1969

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
E. P. Ritchings, M.D.	Pine Bluff State Hospital

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 29 69	Ideal Island	Ideal Island Somerset

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Darbes & West		JUN 3 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-30M REV 1/68)

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07667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07657

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
David	Clarence	Kidd	May	19	1969	11:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
Male	White	Aug. 26, 1884	84 YRS.				

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
N.Y.	USA		Wicomico Md

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	Farmer	Dairy

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
N.Y.	Livingston	Dansville	YES ☐ NO ☒	Route 2

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
George		Kidd	Amanda		Sterner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	Address
No		Mr. David Flint, Morris Dr.,	Salisbury Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Chronic myeloid leukemia	unknown
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

2051

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 5-13, 1969, to 5-19, 1969, that (I) (we) last saw the deceased alive on 5-19 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
[signature]					5-19-69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
Wilbur Ellis Jr.	Medical Center - Salisbury, Md

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5-22-1969	Greenmount Cemetery	Dansville, Livingston, N.Y.

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Thomas F. Wallace, Salisbury, Md.	DATE MAY 22 1969	[signature]

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07663

CERTIFICATE OF DEATH

07658

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
SADIE	B.	LARMORE	May 18, 1969	9:30A M

3. SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	3/30/1878	91 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Md.	U.S.	WIDOWED X	WICOMICO Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Deer's Head State Hospital	Saw Mill Factory	

13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
Maryland	Wicomico	Bivalve		--

14. FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last	
Jacob E. Larmore	Charity Larmore	

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No	—	216-03-6173	Jacob Larmore	Bivalve, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b)	Cardiorenal disease	Years
DUE TO, OR AS A CONSEQUENCE OF (c)		

404 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Pulmonary emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO X	

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (X) (this hospital) attended the deceased from December 22 19 64, to May 18, 1969, that I (I) (we) last saw the deceased alive on May 18, 1969, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
L. V. Maldve, M.D.	M.D.			X	5/19/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. V. Maldve, M. D.	Deer's Head State Hospital, Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/24/69	Bivalve Cem.	Bivalve, Md.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
C. J. Massib	Bivalve, Md	MAY 21 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301-W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07669 07659

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1. DECEASED-NAME (Type or print)	First: ADA	Middle: BLANCHE	Last: LEYDECKER	2a. DATE OF DEATH: Month May Day 3 Year 69	2b HOUR: 3:45 A M
3. SEX: Female	4 RACE: White	5 DATE OF BIRTH: April 13, 1886	6 AGE (In years last birthday): 83 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a BIRTHPLACE (State or foreign country): Kansas	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.		
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springhill Sanitarium	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Secretary	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c CITY OR TOWN: Salisbury	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e STREET AND NUMBER: 617 Ridge Road	
14 FATHER'S NAME First: George	Middle: E.	Last: Mallery	15 MOTHER'S MAIDEN NAME First: Julia	Middle	Last: Walker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT (Son) Address: Mr. Charles Leydecker, Salisbury, Maryland			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardio-vascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4) 14X
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	N/A 19	N/A

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No	City or Town	County	State
	N/A	N/A			

22a. **I certify** that (I) (this hospital) attended the deceased from Dec, 1968 to 5-3, 1969, that (I) (we) last saw the deceased alive on 5-1 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Philip A Insley DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ 22c DATE SIGNED: May - 3 /1969

22d. PHYSICIAN'S NAME (Type): Dr. Philip A. Insley 22e ADDRESS: Main St. Salisbury, Maryland 21801

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 5, 1969	Loudon Park Cemetery Co.	Baltimore Maryland

24 FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY* SALISBURY, MARYLAND	MAY 7 1969	

VR A15 (4)
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07670

CERTIFICATE OF DEATH

07660

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 7-69

1 DECEASED NAME (Type or print) First: Edith	Middle: BRUNT	Last: Logan	2a DATE OF DEATH Month: May Day: 20 Year: 69
2b HOUR: 11:30 P M			
3 SEX: FEMALE	4 RACE: WHITE	5 DATE OF BIRTH: FEBRUARY 13, 1909	6 AGE (In years last birthday): 60 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Admissions Officer	12b. KIND OF BUSINESS OR INDUSTRY: Child. Hos
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Md.	13b. COUNTY: Balto. City	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 528 Nottingham Rd.			
14 FATHER'S NAME First Middle Last: Thomas J. Logan	15 MOTHER'S MAIDEN NAME First Middle Last: Anna Brunt		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no	(If yes give war or dates of service): none	16b SOCIAL SECURITY NO: 215-09-6994	17 INFORMANT Address: Mrs Anna Brunt Logan 528 Nottingham

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardio vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF
(b): Cirrhosis of Liver — Chronic
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a **I certify** that (I) (this hospital) attended the deceased from 5-20, 1969, to 5-21, 1969, that (I) (we) last saw the deceased alive on 5-21 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE: William R. Ellis — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c DATE SIGNED: 5-22-69

22d PHYSICIAN'S NAME (Type): WILBER R. ELLIS JR. — 22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 23, 1969	23c NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery	23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland	
24 FUNERAL DIRECTOR: Sterling Funeral Estate	ADDRESS: 736 Edmondson Ave. Catonsville, Md. 21228	25a. RECEIVED BY REGISTRAR DATE: MAY 26 1969	25b. REGISTRAR'S SIGNATURE: Registrar Judge	

1

07671
Item6 Film6413 6/5/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07661

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
MARIE		MADDOX	MAY	24	1969	4 45 A M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Female	Negro	7/3/1922	46 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH
Maryland	U S A		Wicomico Md

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General		

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13c CITY OR TOWN	13d INSIDE CITY LIMITS YES [ ] NO [X]	13e. STREET AND NUMBER
Maryland	Somerset Princess Anne		

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Benjaim		Barkley	Nellie		Hall

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	Address
		Brisco Barkley	Princess Anne, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio respiratory Failure	4 da
DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinomatosis	6 mos
DUE TO, OR AS A CONSEQUENCE OF (c)	Ca of pancreas	> 6 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1579

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
11/68	(c) above (Whipple)	YES [ ] NO [X]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 5/20, 19 69 to 5/24, 19 69, that (I) (we) last saw the deceased alive on 5/23, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS [ ]	MED DIRECTOR [ ]	STAFF PHYS [X]	22c DATE SIGNED
John M. Steffy	MD				5/25/69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
John M. Steffy	Peninsula Gen. Hosp 21801

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/29/69	Samuel Wesley	Manokin, Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
William H. James JR	Princess Anne, Md	JUN 2 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 12
45M 1/68

07672

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07662

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
MINNIE	W.	MELSON	May 1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Female	White	May 12, 1883	85 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH
Maryland	USA		WICOMICO Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Springhill Sanitarium	Bookkeeper - retired	Lumber Co.

13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	208 New York Avenue

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
John	M.	Wimbrow	Eliza		Parsons

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
No		214-18-4050	Mr. Raymond Wimbrow & Mr. C. Ercell Wimbrow (Brothers)	Salisbury, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio vascular renal disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

404

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a I certify that (I) (this hospital) attended the deceased from Dec, 1968, to 5-11, 1969, that (I) (we) last saw the deceased alive on 5-7 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
Philip A Insley	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	May 12 1969

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
Dr. Philip A. Insley	Salisbury, Maryland

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 14, 1969	Parsons Cemetery	Salisbury, Wicomico, Maryland

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND	MAY 15 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _ hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07673

CERTIFICATE OF DEATH

07663

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	HENRY	Middle J.	Last MESSICK
2a. DATE OF DEATH Month Day Year	May 12, 1969		2b. HOUR 9:10 AM
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	7/4/02		
6. AGE (In years last birthday)	66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	MD		
7b. CITIZEN OF WHAT COUNTRY?	USA		
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	WICOMICO Md.		
10. CITY OR TOWN OF DEATH	Salisbury		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Deer's Head State Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Retired		
12b. KIND OF BUSINESS OR INDUSTRY	Waterman		
13a. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) STATE	Maryland		
13b. COUNTY	Somerset		
13c. CITY OR TOWN	Princess Anne		
13d. INSIDE CITY LIMITS? YES [X] NO [ ]			
13e. STREET AND NUMBER	Main Street		
14. FATHER'S NAME First	Jess	Middle	Last Messick
15. MOTHER'S MAIDEN NAME First	Susie	Middle	Last Messick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO.	unknown		
17. INFORMANT	Julia Tull	Address	Salisbury, Md 21801

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Lymphoma, mediastinal — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Indefinite
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that I (this hospital) attended the deceased from March 5, 19 69, to May 12, 19 69, that I (we) last saw the deceased alive on May 12, 19 69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death

22b. SIGNATURE	C. H. Winnacott, M.D.	DEGREE: ATTENDING PHYS [ ] MED D RECTDR [ ] STAFF PHYS [X]	22c. DATE SIGNED 5/12/69
22d. PHYSICIAN'S NAME (Type)	C. H. Winnacott, M. D.	22e. ADDRESS	Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION REMOVAL (Specify)	Burial	23b. DATE	5/15/69	23c. NAME OF CEMETERY OR CREMATORY	Ford Cemetery
23d. LOCATION (City or Town) (County) (State)	Dames Quarter Som MD				
24. FUNERAL DIRECTOR ADDRESS	Leroy Webster — Princess Anne MD	25a. RECD BY REGISTRAR DATE	MAY 19 1969	25b. REGISTRAR'S SIGNATURE	Wilmer Cooper

VR A15 45M - 4/69

1

07674

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07664

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1538

1. DECEASED-NAME (Type or print)	First: Samuel H	Middle	Last: Moore	2a. DATE OF DEATH Month: May Day: 20 Year: 1969	2b HOUR: M
3 SEX: Male	4 RACE: Col	5 DATE OF BIRTH: 1864-3-2	6 AGE (In years last birthday): 105 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): Wicomico	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md		
10. CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Lather	12b KIND OF BUSINESS OR INDUSTRY: None		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Md	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Welipaun	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: Rural	
14 FATHER'S NAME First: unknown	Middle	Last	15 MOTHER'S MAIDEN NAME First: unknown	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown: No (If yes give war or dates of service)	16b SOCIAL SECURITY NO: None	17 INFORMANT: Minnie Brown	Address: Rural Rte		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: < 10 min

153.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Retroperitoneal Venous Thrombosis — < 10 da

DUE TO, OR AS A CONSEQUENCE OF (c): Ca Colon, Post-op venous stasis — 3-4 mos, < 10 da

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Fecal Fistula

19a. DATE OF OPERATION: 5/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca Colon	20a AUTOPSY? YES ☒ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED Where at work ☐ Not where at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a I **certify** that (I) (this hospital) attended the deceased from 4/27 19 69, to 5/20 19 69, that (I) (we) last saw the deceased alive on 5/20 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: John M. Steffy MD — DEGREE: ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c DATE SIGNED: 5/25/69

22d PHYSICIAN'S NAME (Type): John M. Steffy MD — 22e ADDRESS: Peninsula Gen. Hosp 21801

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5-25-69	23c NAME OF CEMETERY OR CREMATORY: Conway Cem	23d LOCATION (City or Town): Welipaun (County): Wico (State): Md	
24 FUNERAL DIRECTOR: Barkley	ADDRESS	25a REC'D BY REG STRAR DATE: MAY 27 1969	25b REG STRAR'S SIGNATURE: Charles Judge	

VR A45 (4) 45M - 7/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10) 45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07675 07665

1. DECEASED-NAME (Type or print)	First (BABY BOY)	Middle	Last MORGAN	2a. DATE OF DEATH Month MAY	Day 2	Year 1969	2b HOUR 5PM
3 SEX MALE	4 RACE White	5. DATE OF BIRTH May 2, 1969	12:02AM	6 AGE (In years last birthday) 0 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN	
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ Baby	9 COUNTY OF DEATH WICOMICO Md				
10. CITY OR TOWN OF DEATH SALISBURY	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PENINSULA GENERAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIM TS? YES ☐ NO ☐	13e. STREET AND NUMBER 110 Lehigh Ave.			
14. FATHER'S NAME First Richard	Middle Eugene	Last Morgan	15 MOTHER'S MAIDEN NAME First Leona	Middle Barbara	Last Vollkommer		
16a. WAS DECEASED EVER IN U S ARMED FORCES? Yes, no or unknown) No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT (Mother)	Address Mrs. Leona B. Morgan, , Salisbury, Md.			

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Prematurity

DUE TO, OR AS A CONSEQUENCE OF

(b) Premature Birth

DUE TO, OR AS A CONSEQUENCE OF

(c) Possible R.H. factor

7740

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTR BUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f LOCATION Street or R.F.D No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 5/2, 1969, to 5/2, 1969, that (I) (we) last saw the deceased alive on 5/2/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
Wm B Smith					5/2/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. William B. Smith	Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 9, 1969	Wicomico Memorial Park	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND	MAY 14 1969	

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

07676 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07666

1 DECEASED NAME (Type or Print) First	Middle	Last
JAMES	PHILIP	MORRIS

2a DATE KNOWN OF DEATH ESTIMATED ☒ Month 5 Day 18 Year 69 — 2b HOUR 5:45 A M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Male	AA	8/18/1937	31 YRS				

2c. DATE PRONOUNCED DEAD Month 5 Day 19 Year 1969 — 2d HOUR 10 A M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Wicomico Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Mitchell Pond	Factory worker	

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Wicomico	Salisbury	YES ☒ NO ☐	109 Second St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Warner	Morris		Pauline	Ryder	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Pauline Morris 608 Hill St. Salis Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Drowning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 110.1

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	5:45 P.M. 5-18-69	Found drowned.

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. City or Town County State
	pond	Mitchell Pond, Salisbury, Wic., Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED May 19, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/24/69	Green Acress	Salisbury Wicomico Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Clinton Stewart, Salisbury, Md.	MAY 26 1969	Charles Judge

VR A15ME (5) 10M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07677 07667

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First: GEORGE Middle: CAIRNES Last: MURPHY

2a DATE OF DEATH: Month MAY Day 27 Year 1969

2b HOUR: 2:25 P M

3 SEX: Male

4 RACE: White

5 DATE OF BIRTH: 21 Oct. 1897

6 AGE (In years last birthday): 71 YRS.

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN

7a BIRTHPLACE (State or foreign country): Baltimore

7b CITIZEN OF WHAT COUNTRY? U S A

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Wicomico Md

10 CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General

12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.): Service Manager- Auto Sales

12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) STATE: Maryland

13b. COUNTY: Wicomico

13c. CITY OR TOWN: Salisbury

13d INSIDE CITY LIMITS? YES [X] NO [ ]

13e STREET AND NUMBER: 300 New York Ave.

14 FATHER'S NAME First Middle Last: George W. Murphy

15 MOTHER'S MAIDEN NAME First Middle Last: Margaret Males

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) W.W#I

16b. SOCIAL SECURITY NO: 214-10-7773

17. INFORMANT Address: Mrs. Fanny B. Murphy (Wife) (Same as 13e)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute Tracheobronchitis, Atelectasis &

DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonitis, secondary to Advanced Pulmonary Emphysema

DUE TO, OR AS A CONSEQUENCE OF (c) Bleeding Duodenal Ulcer followed by hemigastrectomy & post-colic gastrojejunostomy complicated by a fistula.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Subphrenic abscess & later by a gastric fistula.

9a DATE OF OPERATION: 4-4-69

19b CONDITION FOR WHICH OPERATION WAS PERFORMED: Bleeding Duodenal Ulcer

20a AUTOPSY? YES [X] NO [ ]

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)

21f LOCATION Street or R.F.D. No. City or Town County State

22a I certify that (I) (this hospital) attended the deceased from 4/3/69 19__, to 5/27, 1969, that (I) (we) last saw the deceased alive on 5-27-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Paul H. Cayaves, M.D. DEGREE ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22c DATE SIGNED: 5/28/69.

22d PHYSICIAN'S NAME (Type): Paul H. Cayaves, M.D.

22e. ADDRESS: Salisbury, Maryland

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE: 30 May 1969

23c NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d LOCATION (City or Town) (County) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND

25a RECD BY REGISTRAR DATE: JUN 3 1969

25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07673 — 07668

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, with in 72 hours of death

1. DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b HOUR
ADOLPH	C.	NORSTEDT	May	25,	1969	4:25 AM

3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Male	White	1885	84 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Penna.	USA	NEVER MARRIED [X]	WICOMICO Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Deer's Head State Hospital	Teacher	School

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Dorchester	Taylor's Island	YES [ ] NO [X]	None

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Johann		Norstedt	Katherine		Lewis

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
No	- - -		LeCompte Funeral Service records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

412.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease — Years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Left ureteral calculus

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	Yes

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from April 27, 1965, to May 25, 1969, that (I) (we) last saw the deceased alive on May 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
A. C. Mitchell	ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [X]	5/26/69 Maryland

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
A. C. Mitchell, M. D.	Deer's Head State Hospital, Salisbury,

23a BURIAL CREMATION REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 28, 1969	Episcopal Churchyard	Taylors Island, Maryland

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REG. STRAR DATE	25b REGISTRAR'S SIGNATURE
LeCompte Funeral Service, Cambridge, Maryland	MAY 28 1969	Charles Judge

VR A 5 (1) 45M 11 69

[illegible] 1989 [illegible]

[illegible]

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07679

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07669

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: EDGAR	Middle: CALVIN	Last: PARKS	2a. DATE OF DEATH: Month May Day 30 Year 1969	2b. HOUR: 2:40PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: May 27, 1902	6. AGE (In years last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: WICOMICO Md		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Service Station Attendant	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: Rt. 3, Ocean City Road	
14. FATHER'S NAME First: James	Middle: C.	Last: Parks	15. MOTHER'S MAIDEN NAME First: Ella	Middle:	Last: Rencher
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 578-10-5722	17. INFORMANT (Wife)	Address: Mrs. Nettie F. Parks, Salisbury, Maryland		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple Pulmonary Emboli — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.

DUE TO, OR AS A CONSEQUENCE OF (b): Thrombo phlebitis — yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4549

DUE TO, OR AS A CONSEQUENCE OF (c): Narcotics both legs. — yrs.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from June, 19 54 to 5/30, 19 67, that (I) (we) last saw the deceased alive on 5/30 19 67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: June 1 /1969

22d. PHYSICIAN'S NAME (Type): Dr. E. M. Beardsley — 22e. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 2, 1969	23c. NAME OF CEMETERY OR CREMATORY: St. Stephens Cemetery	23d. LOCATION (City or Town): Delmar	(County):	(State): Delaware
24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE: JUN 6 1969	25b. REGISTRAR'S SIGNATURE: [signature]		

VR A15 (4)
45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07680

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07670

1. DECEASED-NAME (Type or print) First: BESSIE	Middle: VIRGINIA	Last: Payne	2a. DATE OF DEATH Month: May Day: 30 Year: 69 — 2b. HOUR 4:40 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Nov. 4, 1885	6. AGE (In years last birthday): 83 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: --
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: Maryland — 13b. COUNTY: Worcester	13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.F.D. 3
14. FATHER'S NAME First: Elias Middle: Washington Last: Taylor		15. MOTHER'S MAIDEN NAME First: Sarah Middle: -- Last: Aydelotte	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): --	16b. SOCIAL SECURITY NO.: none	17. INFORMANT / Address: Frank T. Taylor, Pocomoke City, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute cholecystitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary insufficiency

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Cerebral insufficiency

19a. DATE OF OPERATION: 5-22-69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Cholecystitis	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 5-19, 1969, to 5-30, 1969 that (I) (we) last saw the deceased alive on 5-30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E. Kent Carney — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: 6-5-69

22d. PHYSICIAN'S NAME (Type): E. KENT CARNEY — 22e. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6-1-1969	23c. NAME OF CEMETERY OR CREMATORY: Remson Methodist	23d. LOCATION (City or Town) (County) (State): Pocomoke City-Wor.-Md.
24. FUNERAL DIRECTOR: Robert N. Watson	ADDRESS: Pocomoke City, Md.	25a. REC'D BY REGISTRAR DATE: JUN 9 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge

Robert N. Watson

VR AI [illegible]
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07681 — 07671

1 DECEASED-NAME (Type or print): First MARY; Middle LOVE; Last PAYNE

2a. DATE OF DEATH: Month MAY; Day 3; Year 1969

2b. HOUR: 12 M

3 SEX: FEMALE

4 RACE: White

5 DATE OF BIRTH: April 10, 1928

6 AGE (In years last birthday): 41 YRS. (If under 1 year: Months, Days; If under 24 hrs: Hours, Min)

7a BIRTHPLACE (State or foreign country): Maryland

7b CITIZEN OF WHAT COUNTRY? USA

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: WICOMICO Md

10 CITY OR TOWN OF DEATH: SALISBURY

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): PENINSULA GENERAL HOSPITAL

12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife

12b KIND OF BUSINESS OR INDUSTRY: ----

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland

13b COUNTY: Wicomico

13c CITY OR TOWN: Salisbury

13d INSIDE CITY LIMITS? YES [X] NO [ ]

13e STREET AND NUMBER: 904 Russell Ave.

14. FATHER'S NAME: First Howard; Middle B.; Last Riggin

15 MOTHER'S MAIDEN NAME: First Lydia; Middle ; Last Coates

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16b SOCIAL SECURITY NO

17 INFORMANT (Husband) Address: Mr. John A. Payne, Salisbury, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Fibrosarcoma of left kidney with — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 month

DUE TO, OR AS A CONSEQUENCE OF: metastasis

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 10/18/68

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Left nephrectomy

20a AUTOPSY? YES [ ] NO [X]

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2/23/69, 19____, to 5/3/69, 19____, that (I) (~~he~~) last saw the deceased alive on 5/3/69 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~he~~) (did) (~~did not~~) view the body after death.

22b SIGNATURE: Raymond M. Yow M.D. DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22c DATE SIGNED: 5/3/69

22d PHYSICIAN'S NAME (Type): Dr. Raymond M. Yow

22e ADDRESS: Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE: May 5, 1969

23c NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a RECD BY REGISTRAR DATE: MAY 7 1969

25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M 1/69

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07682 07672

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARION	CLIFFORD	Phippin	May 31 1969	9:30 PM

3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (If under 1 year last birthday) YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	1/25/93	76		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Siloam, Md.	U.S.	Widowed ✓	Wicomico Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Wicomico Nursing Home	Truck Driver	-

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
Maryland	Wicomico	Hebron		Railroad Avenue

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Henry		Phippin	Josephine		Humphrey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT (Son) Address Phillips Ave.
No	212-10-8955	Mr. Benjamin A. Phippin, Hebron, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Post operative infection — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 575X

DUE TO, OR AS A CONSEQUENCE OF (b) Cholecystectomy — 3 wks

DUE TO, OR AS A CONSEQUENCE OF (c) Gen. arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d. INJURY OCCURRED While / Not while at work	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f. LOCATION Street or R F D No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from May 27, 1969, to May 31, 1969, that (I) (we) last saw the deceased alive on 5/28/1969, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
F. Weaver	MD	✓			6/2/69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Frank L. Weaver	Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	June 4, 1969	Hebron Cemetery	Hebron, Wicomico, Maryland

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND	JUN 5 1969	[signature] Judge

1

07683

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07673

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ELTON	ALFRED	Powell	May	18	1969	7:53 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
Male	White	August 7, 1918	50 YRS				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Wicomico Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	Salesman	Baking Co.

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Parsonsburg	YES ☐ NO ☐	Morris Leonard Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	Ryder	Powell, Sr.	Mary	W.	Brittingham

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service	16b. SOCIAL SECURITY NO	17. INFORMANT (Wife) Address
Yes War II	215-12-6340	Mrs. Mary L. Powell, Parsonsburg, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Pneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 72 hrs

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Chronic Pulmonary Fibrosis — 4 YRS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cor Pulmonale

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ( ) (this hospital) attended the deceased from Sept, 1964 to May 18, 1969, that (I) (we) last saw the deceased alive on May 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED
John T. Bulkeley MD			5-18-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. John T. Bulkeley	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 21, 1969	Wicomico Memorial Park	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND	MAY 22 1969	Charles Judge

VR A15 (R)
45M - 1969

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07684

CERTIFICATE OF DEATH

07674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: JAMES Middle: ELMER Last: Powell	2a. DATE OF DEATH Month: May Day: 3rd Year: 1969	2b. HOUR: 1:20 PM	
3. SEX: Male	4 RACE: White	5 DATE OF BIRTH: March 5 1902	6 AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN.
7a BIRTHPLACE (State or foreign country): Md.	7b CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Worcester Md.
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula Gen. Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Yardmaster	12b KIND OF BUSINESS OR INDUSTRY: Railroad
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Md.	13b COUNTY: Wicomico	13c CITY OR TOWN: Delmar	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 307 E. Grandview Ave.
14 FATHER'S NAME First: Otis Middle: Last: Powell	15. MOTHER'S MAIDEN NAME First: Cora Middle: Last: Taylor		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown: (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: Crystal G. Powell	Address: Salisbury Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Decompensation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Bronchitis & Emphysema — not Known
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Prostatic Carcinoma. & Anemia.

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 4/24, 19 69 to 5/3, 19 69, that (I) (we) last saw the deceased alive on 5/3, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c DATE SIGNED

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 5/5/69	23c NAME OF CEMETERY OR CREMATORY: Mt. Hope Cem.	23d LOCATION (City or Town): Quantico	(County): Wicomico	(State): Md.
24 FUNERAL DIRECTOR: Willard Merrill	ADDRESS: Salisbury Md.	25a RECD BY REGISTRAR DATE: MAY 5 1969	25b REGISTRAR'S SIGNATURE: Charles Judge		

VR A15 (12-68) 45M 1-69

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M 1/69

07685

Items 5,6,7,&8 Film G413 6/9/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07675

1. DECEASED-NAME (Type or print) First: Sallie	Middle: Anna	Last: Purnell	2a. DATE OF DEATH Month: May Day: 27 Year: 1969
2b. HOUR: 3:35 P.M.			
3. SEX: Female	4. RACE: Colored	5. DATE OF BIRTH: Sept. 16, 1895	6. AGE (In years last birthday): 73 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): USA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired):	12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Somerset	13c. CITY OR TOWN: Princess Anne	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: Rt. # 2			
14. FATHER'S NAME First: Robert	Middle:	Last: Hall	15. MOTHER'S MAIDEN NAME First: Martha Middle:	Last: Hall
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: Sonia Stewart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute tracheo-bronchitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

Conditions, if any which gave rise to immediate cause (a) stating the underlying cause last. 485 X

DUE TO, OR AS A CONSEQUENCE OF (b): Bronchopneumonia — Days

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cerebral vascular accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that ☒ (this hospital) attended the deceased from Apr. 24, 1969, to May 27, 1969, that ~~I~~ (we) last saw the deceased alive on May 27 19 69, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: A. C. Mitchell DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22c. DATE SIGNED: 5/28/69

22d. PHYSICIAN'S NAME (Type): A. C. Mitchell, M. D.

22e. ADDRESS: Deer's Head Hospital; Salisbury, Maryland 21801

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 6/I/69

23c. NAME OF CEMETERY OR CREMATORY: St Mark

23d. LOCATION (City or Town) (County) (State): Oakville, Maryland

24. FUNERAL DIRECTOR ADDRESS: William H. James Jr. Princess Anne, Md

25a. RECD BY REGISTRAR DATE: JUN 4 1969

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

07686

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07676

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (Page 1 and Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AUG 14 45M 7/69

1. DECEASED-NAME (Type or print)	First: ALMA	Middle: C.	Last: RIGGIN	2a. DATE OF DEATH Month: May	Day: 20,	Year: 1969	2b. HOUR: 2:35PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: June 19-1880	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS: ---- DAYS:	IF UNDER 24 HRS.: HOURS: MIN:		
7a. BIRTHPLACE (State or foreign country): Md	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: WICOMICO Md				
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired	12b. KIND OF BUSINESS OR INDUSTRY: household				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Somerset	13c. CITY OR TOWN: Crisfield	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: Somerset Avenue			
14. FATHER'S NAME First: A	Middle: R	Last: Crockett	15. MOTHER'S MAIDEN NAME First: Lillian	Middle: J	Last: Lawson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: Unknown	17. INFORMANT: Thomas Riggin	Address: Crisfield Md			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Pulmonary Embolus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular Disease — Years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Cerebral Thrombosis; Carcinoma of Right Breast

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from June 28, 19 66, to May 20, 19 69, that (I) (we) last saw the deceased alive on May 20, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS ☒	22c. DATE SIGNED: 5/20/69
22d. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.	22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 23-69	23c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Park	23d. LOCATION (City or Town): Crisfield	(County): Som	(State): Md
24. FUNERAL DIRECTOR: Leroy Webster	ADDRESS: Princess Anne Md	25a. RECD BY REGISTRAR DATE: MAY 27 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge		

1

07687

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07677

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. DECEASED-NAME (Type or print): First ROBERT Middle JAMES Last SHORES
2a. DATE OF DEATH: Month MAY Day 10 Year 1969
2b. HOUR: 4 40 PM
3. SEX: MALE
4. RACE: W.
5. DATE OF BIRTH: APRIL 15-1883
6. AGE (In years last birthday): 86 YRS. IF UNDER 1 YEAR: MONTHS — DAYS — IF UNDER 24 HRS: HOURS — MIN —
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired
12b. KIND OF BUSINESS OR INDUSTRY: Waterman
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.
13b. COUNTY: Som.
13c. CITY OR TOWN: CHANCE
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: MAIN ROAD
14. FATHER'S NAME First JOHN Middle W Last STORES
15. MOTHER'S MAIDEN NAME First ELIZABETH Middle — Last TIGNOR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service): NO
16b. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT Address: VERA BLOODSWORTH CHANCE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): generalized arteriosclerosis — 4 YRS
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Diabetes Mellitus

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 4-22, 1969, to 5-10, 1969, that (I) (we) last saw the deceased alive on 5-10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John C Bulkeley M.D. DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 5-10-69
22d. PHYSICIAN'S NAME (Type): John BULKELEY
22e. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5/13/69
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Chance Som. Md.
24. FUNERAL DIRECTOR: Leroy Webster
ADDRESS:
25a. RECEIVED BY REGISTRAR DATE: MAY 19 1969
25b. REGISTRAR'S SIGNATURE:

VR A15 45M - 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death any delay is necessary, please execute the certificate, writing the word "pending" in part(s) in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

07688 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07678

1. DECEASED-NAME (Type or Print)	First: CHARLES	Middle: LEROY	Last: SISCO					2a DATE KNOWN OF DEATH ESTIMATED ☒	Month: 5	Day: 17	Year: 69	2b HOUR: 1 P M
3 SEX: Male	4 RACE: W	5 DATE OF BIRTH: 8-3-1893	6 AGE (In years last birthday): 75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / M.N			2c. DATE PRONOUNCED DEAD	Month: 5	Day: 17	Year: 69	2d HOUR: 2 P M
7a BIRTHPLACE (State or foreign country): N.J.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Wicomico Md									
10 CITY OR TOWN OF DEATH: Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): retired plumber	12b. KIND OF BUSINESS OR INDUSTRY: plumbing									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Wicomico	13c. CITY OR TOWN: Bivalve	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER								
14 FATHER'S NAME First: Charles	Middle	Last: Sisco	15 MOTHER'S MAIDEN NAME First	Middle	Last: Hatzel							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO.: 138-28-7351	17. INFORMANT: Mrs Edward Van Cott	ADDRESS: Ramsey, N.J.									

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: May 19, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
burial	5-20-69	Go. Washington Mem. Park, Paramus	N.J.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Messick Funeral Home, Bivalve, Md.	MAY 21 1969	

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07689 — 07679

1 DECEASED-NAME (Type or print): First CHARLES; Middle ALBERT; Last SKIRVEN

2a DATE OF DEATH: Month May; Day 8; Year 1969

2b HOUR: 7:10 PM

3 SEX: Male

4. RACE: White

5. DATE OF BIRTH: July 2, 1899

6 AGE (In years last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN)

7a BIRTHPLACE (State or foreign country): Maryland

7b CITIZEN OF WHAT COUNTRY?: USA

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: WICOMICO Md.

10. CITY OR TOWN OF DEATH: Salisbury

NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital

12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): District Engineer

12b KIND OF BUSINESS OR INDUSTRY: State Road Com.

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland

13b COUNTY: Wicomico

13c CITY OR TOWN: Salisbury

13d INSIDE CITY LIMITS? YES [X] NO [ ]

13e STREET AND NUMBER: 223 New York Avenue

14. FATHER'S NAME First: Charles; Middle: Howard; Last: Skirven

15 MOTHER'S MAIDEN NAME First: Clara; Middle: Asenath; Last: Keyser

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b SOCIAL SECURITY NO.: 212-14-4378

17. INFORMANT (Wife): Address 223 New York Avenue
Mrs. Alden R. Skirven, Salisbury, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 72 hours

485 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus.
Cerebral thrombosis with left hemiplegia; hypertensive arteriosclerotic ht.dis.

19a. DATE OF OPERATION:

19b CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]

21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC.)

21f LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from April 8, 1969, to May 8, 1969, that (I) (we) last saw the deceased alive on May 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: C. H. Winnacott M.D. DEGREE: ATTENDING PHYS [ ] MED. DIRECTOR [ ] STAFF PHYS [X]

22c DATE SIGNED: 5/9/69

22d PHYSICIAN'S NAME (Type): C. H. Winnacott, M. D.

22e ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE: May 11, 1969

23c NAME OF CEMETERY OR CREMATORY: Old St. Paul Church Cemetery

23d LOCATION (City or Town) (County) (State): Chestertown Maryland

24 FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a RECD BY REGISTRAR DATE: MAY 13 1969

25b REGISTRAR'S SIGNATURE: Stanley Goodyear

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (3)
45M - 1-69

1

07690

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07680

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event with in 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
ROBERT		SMITH	May 27, 1969	4:00 AM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	Colored	AUGUST 4, 1906	62 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		WICOMICO Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Deer's Head State Hospital	LABORER	

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Dorchester	Cambridge	YES ☒ NO ☐	602 Edgewood Avenue

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH		SMITH	SARAH		CREIGHTON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
NO	220-28-1278	GLADYS ROWLEY	624 DOUGLAS ST. 21613

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral vascular accident with left hemiplegia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypertensive arteriosclerotic cardiovascular disease — Yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that ~~I~~ (this hospital) attended the deceased from April 17, 1969, to May 27, 1969, that ~~I~~ (we) last saw the deceased alive on May 27, 1969, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) ~~did~~ ~~XXXX~~ view the body after death.

22b SIGNATURE	DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒	22c DATE SIGNED
A. C. Mitchell		5/27/69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
A. C. Mitchell, M. D.	Deer's Head State Hospital, Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	5/30/69	UNION CHAPEL	CORDTOWN DOR. MD.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Frederick C. St. Clair	ST. CLAIR F. HOME CAMBRIDGE, MD.	JUN 3 1969	Beverly Judge

VR A15 14 45M 7/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07681

1 DECEASED-NAME (Type or Print) First	Middle	Last					2a DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b HOUR
MARTHA	MAE	SMULLEN					5/11		1969	4:40 P M
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR
Female	White	Jan. 3, 1922	47 YRS					May	11	1969	4:40 P M

7a BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH WICOMICO Md	
10. CITY OR TOWN OF DEATH Salisbury	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress	12b KIND OF BUSINESS OR INDUSTRY Shirt Factory	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Wicomico	13c CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER 2313 Pineway

14. FATHER'S NAME First / Middle / Last	John Slaughter	15 MOTHER'S MAIDEN NAME First / Middle / Last	Lula Mae Frampton
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No	16b SOCIAL SECURITY NO 212-14-4556	17 INFORMANT (Husband) ADDRESS 2313 Pineway Mr. Herman M. Smullen, Salisbury, Maryland

MED CAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bichloride of Mercury Poisoning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A M	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
	11:30 ~~P M~~ 5-11-69	Pt. ingested bichloride of mercury tablets		
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) own home	21f LOCATION Street or R F D No	City or Town	County / State
		2313 Pineway,	Salisbury,	Wicomico, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Earl L. Royer, M.D. M.D

409 Camden Ave., Salisbury, Md. ADDRESS (Street, city, town, or county)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED CAL EXAMINER ☐
DEPUTY MED CAL EXAMINER ☒

22b DATE SIGNED May 12 /1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 14, 1969	Wicomico Memorial Park	Salisbury, Wicomico, Maryland

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND	MAY 15 1969	

VR A15ME (5) 10M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death in any de ay is necessary, please execute the certificate, writing the word "pending" in part I in Item 18. Give Page 1 and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07692 07682

1. DECEASED-NAME (Type or Print) First	Middle	Last
ROLAND	THOMAS	SMULLEN

2a DATE KNOWN OF DEATH ESTIMATED: Month 5/10 Day Year 1969 — 2b HOUR 6.45 P M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.
Male	White	Feb. 7, 1955	14 YRS				

2c DATE PRONOUNCED DEAD Month May Day 10 Year 19 69 — 2d HOUR 7:10 P M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	NEVER MARRIED [X]	WICOMICO Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Riverside Drive	none - student	--

13a USUAL RES DENCE (Where deceased l ved if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Wicomico	Fruitland	YES [ ] NO [ ]	Green Street

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Marion	R.	Smullen	Lola	M.	Smith

16a WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT (Father) ADDRESS
No		Green St. Mr. Marion R. Smullen, Fruitland, Maryland

MED CAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning — APPROX MATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	6:45 PM 5-10-69	Drowned attempting to secure boat.

21d INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK [X]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D. No	City or Town	County	State
	Wicomico River at	Riverside Drive,	Salisbury,	Wic.,	Md.

22a. I **certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Earl L. Royer M D

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MED CAL EXAM NER [X]

22b DATE SIGNED May 12 /1969

23a BUR AL, CREMAT ON, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 12,1969	Wicomico Memorial Park	Salisbury, Wicomico, Maryland

24. FUNERAL D RECTOR ADDRESS	25a REC D BY REGISTRAR DATE	25b REG STRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND	MAY 14 1969	

VR A15ME (5) 10M REV 1/68

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

07693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07683

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) First	Middle	Last
EMILY	JANE	SPENCE

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 5 Day 25 Year 1969 — 2b. HOUR 8:25 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN
F	AA	3-21-31	38 YRS				

2c. DATE PRONOUNCED DEAD Month 5 Day 25 Year 1969 — 2d. HOUR 9 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Berlin	U.S.A	NEVER MARRIED [X]	Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	laborer	chicken

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Worcester	Berlin	YES [ ] NO [X]	Rt. 3, Box 389A

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Horace		Spence	Minnie		Tingle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	214-28-3499	Evelyn Spence	Rt #3 Box 389A Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Fractured skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR AM PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	8:25 PM 5-25-69	Involved in auto accident.

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	highway	Route 12	Snow Hill,	Worcester,	Md.

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md

22b. DATE SIGNED May 27, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5-29-69	Cedar Chapel	Newark, Worcester, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Jolley Funeral Home	Salisbury, Md.	JUN 2 1969	Chandler Judge

VR A15ME 10M - 1, 69

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07694

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07684

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First: OLIVER Middle: JEROME Last: TAYLOR		2a. DATE OF DEATH Month: May Day: 5, Year: 1969	2b. HOUR: 10:26 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: November 22, 1912	6. AGE (In years last birthday): 56 YRS. UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: WICOMICO Md
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Farm
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: Maryland	13b. COUNTY: Caroline	13c. CITY OR TOWN: Federals-burg	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: Rt. #1, Box 78			
14. FATHER'S NAME First: Oliver Middle: M. Last: Taylor		15. MOTHER'S MAIDEN NAME First: Nellie Middle: R. Last: Rowins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	(If yes, give war or dates of service): WW II	16b. SOCIAL SECURITY NO: 215-10-7243	17. INFORMANT Address: Mrs. Marian B. Taylor, Federalsburg, Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cerebral thrombosis with residual left hemiplegia, old; small pulmonary emboli

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from April 23, 1969, to May 5, 1969, that (I) (we) last saw the deceased alive on May 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C. H. Winnacott M.D. DEGREE	ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: 5/5/69	
22d. PHYSICIAN'S NAME (Type): C. H. Winnacott, M. D.	22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: May 7, 1969	23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery	23d. LOCATION (City or Town) (County) (State): Federalsburg, Caroline, Md.	
24. FUNERAL DIRECTOR ADDRESS: Frampton Funeral Home, Federalsburg, Md.	25a. REC'D BY REGISTRAR DATE: MAY 8 1969	25b. REGISTRAR'S SIGNATURE: Elizabeth Jones		

VR A15 (4) 45M - 1-68

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07695

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07685

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

1 DECEASED-NAME (Type or print)	First: EVA	Middle: DAVIS	Last: TINGLE	2a DATE OF DEATH Month: 5	Day: 12	Year: 1969	2b HOUR: 11 A.M
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: NOV 1, 1889	6 AGE (In years last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: WICOMICO Md.				
10. CITY OR TOWN OF DEATH: PITTSVILLE	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): RAILROAD AVE	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: MARYLAND	13b. COUNTY: WICOMICO	13c CITY OR TOWN: PITTSVILLE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: R.R. AVE.			
14. FATHER'S NAME First: MINOS	Middle: A	Last: DAVIS	15. MOTHER'S MAIDEN NAME First: KATE	Middle:	Last: SMITH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 212-22-6707	17 INFORMANT: MR. LEAMON TINGLE	Address: PITTSVILLE, MD				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

1) IMMEDIATE CAUSE (a): Coronary artery disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 hours

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerosis — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Fractured hip 2 yrs ago → inactivity

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from May 12, 1969, to May 12, 1969, that (I) (we) last saw the deceased alive on May 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Frank Lewis Sr. M.D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 5/12/1969	
22d. PHYSICIAN'S NAME (Type): DR FRANK R. LEWIS, SR.	22e. ADDRESS: WILLARDS, MARYLAND		

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 5/14/1969	23c. NAME OF CEMETERY OR CREMATORY: Pittsville Cemetery	23d LOCATION (City or Town): Pittsville, Wic. Md	(County) (State)
24 FUNERAL DIRECTOR: Hill Funeral Home	ADDRESS: Salisbury, Md.	25a. RECD BY REGISTRAR DATE: MAY 16 1969	25b. REGISTRAR'S SIGNATURE	

1

07696

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07686

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b HOUR
MURRAY	CLEVELAND	Walston	May	31	1969	M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Male	White	March 14, 1882	87 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Wicomico Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	Retired Farmer & School Bus Operator	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES ☐ NO ☐	R.F.D. 3

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Eugene	M.	Walston	Tabitha		Perdue

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT (Son)	RFD 7 Address
No	218-34-8885A	Mr. John C. Walston,	Salisbury, Maryland

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. — years.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None.

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from 5-31, 1969, to 5-31, 1969, that (I) (we) last saw the deceased alive on 5-31 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Joseph C. Fitzgerald	M.D.	☒	☐	☐	5-31-69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
Dr. Joseph C. Fitgerald	Salisbury, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	June 3, 1969	Parsons Cemetery	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND	JUN 5 1969	Francis Judge

VR A15 (4-68) 45M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07697 (07687)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First Earl; Middle M.; Last WHITE
2a. DATE OF DEATH: Month MAY; Day 11; Year 1969
2b. HOUR: 4 P.M.
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: 2/27/1895
6. AGE (In years last birthday): 74 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS: HOURS; MIN
7a. BIRTHPLACE (State or foreign country): Md.
7b. CITIZEN OF WHAT COUNTRY? U.S.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Employee
12b. KIND OF BUSINESS OR INDUSTRY: Atlantic O.I Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: Wicomico
13c. CITY OR TOWN: White Haven
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER
14. FATHER'S NAME: First Adolphus; Middle J; Last White
15. MOTHER'S MAIDEN NAME: First Martha; Middle; Last Robertson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes give war or dates of service) WW I
16b. SOCIAL SECURITY NO.: 214-10-875
17. INFORMANT: Earl White, Jr. Address: Mt. Vernon, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure — 1 yr.
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic H-D.
4123
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Uremia. Diabetes Mellitus.
19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 5/4/, 1969, to 5/11/, 19 69, that (I) (we) last saw the deceased alive on 5/11/ 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Oswald Buxton MD
DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 5/11/69
22d. PHYSICIAN'S NAME (Type): Oswald Buxton MD
22e. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5/13/69
23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Mem. Gardens
23d. LOCATION (City or Town) (County) (State): Easton, Md.
24. FUNERAL DIRECTOR: C.O. Messick
ADDRESS: Delmar, Md.
25a. REC'D BY REGISTRAR DATE: MAY 13 1969
25b. REGISTRAR'S SIGNATURE: Wanda Andrew

VR A15 (A)
45M - 1/69

07698

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07688

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Myrtle	Ann	Wilkins	May 18 69	5 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	Feb. 14 1893	76 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Del.	U.S.		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	Housewife	Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Md	Wicomico	Delmar		502 East St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles		Mitchell	Mary		Adkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
—		Carl L. Wilkins	Delmar Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs plus
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Harold J. Gibson					

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/21/69	Parsons Corp	Salisbury Wicomico Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tilghman A. Morris	Delmar Del.	MAY 20 1969	Charles Judge

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VR A15 (Rev. 45M - 68)